90-327 ①

Supreme Court, U.S.
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No. ——

IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

THE MUTUAL LIFE INSURANCE COMPANY OF NEW YORK,
NANCY A. HIORTDAHL and DON LUHRSEN,
Petitioners,
v.
TELLY KANAKIS and PATRICIA KANAKIS,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF CALIFORNIA

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QUESTIONS PRESENTED

1. Whether in their effort to avoid ERISA preemption, the California state courts have erred in failing to apply this Court's reasoning in *Shaw v. Delta Airlines*, 463 U.S. 85 (1983), which compels the rejection of a requirement that an employer must have a motive or an intent to establish an ERISA plan for a plan to be governed by ERISA.

2. Whether the existence of a "welfare benefit plan" as defined under ERISA is contingent upon an employer's participation in the administration of the welfare benefit plan.

PARTIES TO THE PROCEEDING

The Mutual Life Insurance Company of New York,* Nancy A. Hiortdahl and Don Luhrsen.

Telly Kanakis and Patricia Kanakis.

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* Pursuant to Rule 29.1 of the Rules of this Court, the following constitutes a list of all parent companies, non-wholly owned subsidiaries, and affiliates of Petitioner: The Mutual Life Insurance Company of New York has a controlling interest in, but does not wholly own, Institutional Assets, Limited.

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In The

Supreme Court of the United States

October Term, 1990

No. ———

The Mutual Life Insurance Company of New York,
Nancy A. Hiortdahl and Don Luhrsen,
Petitioners,

v.

Telly Kanakis and Patricia Kanakis,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF CALIFORNIA

The Petitioners, The Mutual Life Insurance Company of New York, Nancy A. Hiortdahl and Don Luhrsen (collectively, "Mutual Of New York") respectfully request that a writ of certiorari issue to examine the denial of a petition for review by the Supreme Court of California, on May 23, 1990, which affirmed the decision and judgment of the Court of Appeal, Fourth Appellate District, filed on February 28, 1990.

OPINION BELOW

The May 23, 1990 Order of the Supreme Court of California denying review is in the Appendix at 1a. The February 28, 1990 decision and judgment of the Court of Appeal, Fourth Appellate District is in the Appendix at 2a. The September 18, 1987 judgment on special verdict of the Trial Court is in the Appendix at 26a.

JURISDICTIONAL STATEMENT

The jurisdiction of this Court is invoked pursuant to 28 U.S.C. 1257(a) (1988).

CONSTITUTIONAL PROVISIONS, STATUTES AND REGULATIONS INVOLVED

This case involves §§ 2 and 3 of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001 and 1002 (1982), set forth in the Appendix at 35a.

STATEMENT OF THE CASE

On November 29, 1983, Respondent Telly Kanakis was injured in a motorcycle accident. Mr. Kanakis was covered under a medical insurance plan issued by the Southern California Retail Clerks Union and Food Employers Benefit Fund (the "Benefit Fund Plan"). Mr. Kanakis was also covered as a dependent under a group major medical plan issued by Mutual Of New York to Insurance Systems Incorporated ("ISI"), which covered his wife, Respondent Patricia Kanakis, who was an employee of ISI (the "ISI Plan"). Mr. Kanakis was, therefore, covered under two independent medical insurance plans—the Benefit Fund Plan as an employee and the ISI Plan as a dependent. Appendix ("App.") at 4a.

After the accident, Mr. Kanakis filed claims for medical benefits under both plans. Mutual Of New York reviewed the ISI Plan's Coordination of Benefits ("COB") provision, which is in all material respects a verbatim reproduction of an approved California Administrative Code form, Cal. Admin. Code tit. 10, §§ 2232.50-60, and determined that the claim was primarily covered by the Benefit Fund Plan. App. at 5a. Mr. Kanakis, however, elected to withdraw his claim under the Benefit Fund Plan, as he was interested not in coverage, but a windfall, which the COB provision is designed to avoid.[1] Mutual Of New York did not pay the claim in reliance upon the ISI Plan's COB provision. This caused the Kanakises to sue Mutual Of New York for claim benefits, emotional distress, and punitive damages.

Mutual Of New York believed that the ISI Plan is an "employee welfare benefit plan" pursuant to Section (3)(1) of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1002(1) (1982) ("ERISA"). Mutual Of New York asserted that the Kanakises' common law claims were therefore preempted. The Kanakises conceded and the California Court of Appeal specifically held that if the ISI Plan is an ERISA plan, under the holdings of the California Supreme Court in *Commercial Life Ins. Co. v. Superior Court*, 47 Cal. 3d 473 (1988), and this Court in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), their common law claims are preempted by ERISA. App. at 7a-8a.

In accordance with the requirements of ERISA, the ISI Plan was described in a booklet entitled "Group Insurance Benefits" that was distributed to employees. App. at 13a, 50a. The benefit booklet contained the eligibility requirements, the claims procedure for obtaining benefits, and the procedure to follow if a claim were denied. App. at 54a, 71a. The financing of the ISI Plan was arranged through premiums paid by ISI to Mutual Of New York. For employees, such as Mrs. Kanakis, ISI paid the entire premium. For eligible dependents, such as Mr. Kanakis, the ISI employee paid $50 per month and ISI paid the balance. App. at 13a. ISI negotiated for the acquisition of the medical insurance plan for its employees and their dependents; instituted the insurance application and enrollment process for its employees; informed Mutual Of New York of new employees of ISI; and acted as the conduit for its employees' questions on issues relating to coverage, payment of benefits, or other matters. App. at 39a-42a.

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[1] In November 1984 Mr. Kanakis recovered a $50,000 settlement from the third party motorist who was involved in the accident. App. at 4a. This settlement amount exceeded the total medical expenses incurred as a result of the accident. Had Mr. Kanakis not withdrawn his claim to the Benefit Fund Plan and had he been paid, he would have been required to reimburse the Benefit Fund Plan. App. at 7a.

Less than four months prior to the accident, ISI distributed an announcement to its employees, including Mrs. Kanakis, that it had arranged for a "plan, denominated the [ISI] Employee Benefit Plan" to provide ISI's employees and dependents with medical coverage. App. at 42a-43a. The announcement stated that the ISI Plan was "designed to meet the requirements of the Employee Retirement Income Security Act of 1974 (commonly known as ERISA)." Accompanying this announcement was a "Statement of ERISA Rights." App. at 46a-49a.

The jury was instructed on the five elements of an ERISA plan pursuant to *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982). Court's Special Instruction No. 2, app. at 44a. The Trial Court then instructed the jury that:

> The second of the elements listed [in Special Instruction No. 2] to prove an ERISA employee benefit plan exists—(the plan, fund or program is) *established or maintained*—is proved if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits, *and if ISI intended to establish an ERISA plan, being aware that the plan existed* [emphasis added]. (*Wayne Chemical, Inc. v. Columbus Agency Serv.*, 567 F.2d 692, 699; *Donovan v. Dillingham*, 688 F.2d 1367, 1373.)

Court's Special Instruction No. 4, app. at 45a.

Based on the Trial Court's erroneous instruction, the jury determined that the ISI Plan was not an ERISA plan. App. at 27a. The jury awarded damages of $36,897.69 for the medical expenses, $125,000 for emotional distress, and punitive damages of $500,000. App. at 7a.

In its unpublished opinion, the California Court of Appeal affirmed. Contrary to established case law, the Court of Appeal agreed with the Trial Court's "intent" requirement when it stated that:

> We hold that as a prerequisite to the creation and the existence of an ERISA plan, the employer must intend to create and to participate in such a plan. Such intent may be found in acts as well as words.

App. at 15a.

In addition, the Court of Appeal created a new requirement:

> The existence of an ERISA plan depends upon the extent to which the employer is involved in the administration of the benefit program so as to implicate the concerns which gave rise to ERISA.

App. at 13a.

The California Court of Appeal has thus upheld "employer intent" and "employer administration" as necessary elements of an ERISA plan and the Supreme Court of California has declined to review that decision. This holding invites evasion by state courts of the preemption doctrine established by *Pilot Life.* This erroneous application of existing case law also invites the imposition of this Court's summary adjudication authority.

REASONS FOR GRANTING THE WRIT

I. THE STATE COURT'S HOLDING THAT A PREREQUISITE TO THE CREATION OF AN ERISA PLAN IS A FINDING OF THE EMPLOYER'S INTENTION THAT ERISA GOVERN THE PLAN IS CONTRARY TO THIS COURT'S DECISION IN *SHAW*

Section 3(3) of ERISA, 29 U.S.C. § 1002(3), defines "employee benefit plan" or "plan" as "an employee welfare benefit plan or an employee pension benefit plan" or both. The definition of an "employee welfare benefit plan" is set forth in ERISA § 3(1), 29 U.S.C. § 1002(1):

> (1) The terms 'employee welfare benefit plan' and 'welfare plan' mean *any plan fund, or program* which was heretofore or is hereafter established by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, *through the purchase of insurance or otherwise (A) medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death* . . . . (Emphasis added.)

The California Court of Appeal specifically held that "as a prerequisite to the creation and the existence of an ERISA plan, the employer must intend to create and to participate in such a plan." App. at 15. An "intent" requirement is contrary to the rule of *Donovan v. Dillingham,* 688 F.2d 1367 (11th Cir. 1982) and the numerous circuit courts that have adopted it, and contravenes this Court's reasoning in *Shaw v. Delta Airlines,* 463 U.S. 85 (1983).

In *Donovan v. Dillingham,* 688 F.2d 1367 (11th Cir. 1982), the Eleventh Circuit summarized the criteria for determining whether a group insurance plan constitutes an "employee welfare benefit plan" under 29 U.S.C. § 1002(1) as follows:

> By definition, then, a welfare plan requires (1) a 'plan, fund or program' (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to participants or their beneficiaries.

Id. at 1371. The *Dillingham* standard has been adopted by the Second, Fifth, Seventh, Eighth, Ninth and Eleventh Circuits in determining the existence of an ERISA plan.[2]

The Trial Court instructed the jury on the *Dillingham* elements of an ERISA plan. Court's Special Instruction No. 2, app. at 44a. Rather than end its instruction with the *Dillingham* criteria, however, the Trial Court imposed the additional requirement that Mutual Of New York establish that ISI *"intended to establish an ERISA plan"* when it made the decision to provide group medical benefits to its employees.[3] Court's Special Instruction No. 4, app. at 45a [emphasis added]. Mutual Of New York proved by uncontroverted and substantial evidence at trial that the ISI Plan satisfied every element of "an employee welfare benefit plan" subject to ERISA as enunciated by *Dillingham* and 29 U.S.C. § 1002(1). *See infra* pp. 3-4. The jury, as a result of the erroneous instruction requiring intent, nevertheless held that the ISI Plan was not an ERISA plan.

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[2] Second Circuit (*Bausch & Lomb, Inc. v. Smith*, 630 F. Supp. 262, 263 (W.D.N.Y. 1986)); Fifth Circuit (*Light v. Blue Cross and Blue Shield of Alabama, Inc.*, 616 F. Supp. 558, 561 (S.D. Miss. 1985)); Seventh Circuit (*Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986)); Eighth Circuit (*Harris v. Arkansas Book Co.*, 794 F.2d 358, 360 (8th Cir. 1986)); Ninth Circuit (*Credit Managers Ass'n of Southern California v. Kennesaw Life & Acc. Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987)); and Eleventh Circuit (*Blue Cross & Blue Shield of Alabama v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258, 1267 (N.D. Ala. 1983)).

[3] The Trial Court imposed this additional element in reliance upon *Wayne Chemical v. Columbus Agency Service Corp.*, 567 F.2d 692 (7th Cir. 1977). App. at 45a. *Wayne Chemical*, however, states merely that establishing a plan "requires an intent which presupposes an awareness of the existence of the plan." *Id.* at 699. That language does not support an instruction that specific intent is required to establish an ERISA plan. Indeed, even the court that decided *Wayne Chemical* has embraced the *Dillingham* criteria. (*Ed*

In *Shaw*, this Court addressed the question of whether a disability plan was subject to Section 4(b)(3) of ERISA. Section 4(b)(3) exempts from ERISA coverage "any employee benefit plan . . . maintained solely for the purpose of complying with applicable . . . disability insurance laws." *Shaw, supra*, 463 U.S. at 106. Since the disability plan was broader than required by New York's Disability Benefits Law, this Court held that the plan was not maintained "solely" for the purpose of compliance with that law and was, therefore, preempted by ERISA. This Court stated that the employer's *intent* in establishing a plan providing greater benefits than required under state law had no bearing on whether that plan was governed by ERISA:

> As the Court noted in *Alessi* [*v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, (1981)], plans that not only provide benefits required by such law, but also 'more broadly serve employee needs as a result of collective bargaining', are not exempt [from ERISA preemption]. *The test is not one of motive*—any employer could claim that it provided disability benefits altruistically, to attract good employees, or to increase employee productivity, as well as to obey state law—but whether the plan as an administrative unit, provides only those benefits required by the applicable state law.

(*Shaw, supra*, 463 U.S. at 107 [emphasis supplied].)

Miniat, Inc. v. Globe Life Ins. Group, Inc., 805 F.2d 732, 738 (7th Cir. 1986) [holding that the employer need only intend "to provide benefits for its employees"].)

The California courts' imposition of employer intent to establish an "employee welfare benefit plan" under ERISA is inconsistent with this Court's holding in *Shaw*. In accordance with *Shaw*, an objective analysis of the plan not the motive or intent of an employer, is required to determine whether the plan is governed by ERISA. As a matter of sound public policy, as well as correct legislative interpretation, it is clear that employer intent is irrelevant, and could never be an essential element in establishing the existence of an ERISA plan. To hold otherwise would create an untenable subjective standard, inconsistent with the mandates of this Court.

II. THE STATE COURT ERRED IN HOLDING THAT THE EXISTENCE OF AN ERISA PLAN DEPENDS UPON THE EMPLOYER'S INVOLVEMENT IN THE ADMINISTRATION OF THE BENEFIT PROGRAM

A. The State Court's Holding Is Contrary to Decisions of Federal Courts of Appeals

In erroneously rejecting the application of ERISA to plans that are funded by insurance and administered by an insurer, the California Court of Appeal mistakenly relied upon this Court's holding in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), to support its holding that the existence of an ERISA plan depends upon the employer's involvement in the administration of the benefit program. App. at 13a-14a.

In *Fort Halifax*, this Court determined that a one-time severance payment to employees impacted by a plant closing did not fall within the scope of *ERISA*. The Court reasoned that ERISA was not invoked by a "one-time, lump-sum payment triggered by a single event" which did not require any administration of a plan and where the employer assumed "no responsibility to pay benefits on a regular basis." *Fort Halifax, supra,* 482 U.S. at 12. The California Court of Appeal has reasoned that this Court's search for administrative activity in *Fort Halifax* can only be satisfied by a finding that an *employer* engages in such activity. Thus, the California Court of Appeal held that "ERISA preemption presumes some specie of administrative activities by the employer. . . . " App. at 11.

The California Court of Appeal's holding is in direct conflict with decisions of the Seventh, Ninth, Tenth, and Eleventh federal courts of appeals. Those circuit courts have rejected the requirement that the employer must be directly involved in administration of the benefit plan to qualify the plan under ERISA. See *Brundage-Peterson v. Compcare Health Services Ins. Corp.,* 877 F.2d 509, 511 (7th Cir. 1989) ("the contingent feature of a true welfare benefits plan . . . is unaffected by the delegation of administration of the plan to an insurance company—a delegation contemplated by the statute"); *Credit Managers Ass'n of Southern California v. Kennesaw Life & Accident Ins. Co.,* 809 F.2d 617, 625 (9th Cir. 1987) (an employer "can establish an ERISA plan rather easily. Even if the employer does no more than arrange for a 'group-type insurance program' it can establish an ERISA plan, unless it is a mere advertiser that makes no contributions on behalf of its employees"); *Roe v. General American Life Insurance Co.,* 712 F.2d 450, 452 (10th Cir. 1983); *Dillingham, supra,* 688 F.2d at 1373 (11th Cir. 1982) ("the purchase of a group policy or policies covering a class of employees offers substantial evidence that a plan, fund, or program has been established").

ERISA specifically contemplates the extensive role insurance (and insurers) will play in the administration of an employee benefit plan. ERISA § 3(1), 29 U.S.C. § 1002(1), expressly provides for employee benefit plans that, "through the purchase of insurance," provide benefits in the event of sickness. In rejecting the holding of

Taggart v. Life & Health Benefit Administration, Inc., 617 F.2d 1208 (5th Cir. 1980), a case that the California Court of Appeal cited in establishing its employer administration requirement, the *Dillingham* court stated:

> If *Taggart* implies that an employer or employee organization that only purchases a group health insurance policy or subscribes to a [multiple employer trust] to provide health insurance to its employees or members cannot be said to have established or maintained an employee welfare benefit plan, we disagree. To that extent *Taggart* shall no longer be binding in the Eleventh Circuit.

Dillingham, supra, 688 F.2d at 1375.

ERISA also expressly authorizes the allocation of administrative duties to third parties. 29 U.S.C. § 1105(c)(1). Indeed, ERISA defines the plan "administrator" as including "(i) the person specifically so designated by the terms of the instrument under which the plan is operated [or] . . . (ii) if an administrator is not so designated, the plan sponsor. . . ." 29 U.S.C. § 1002(16)(A)(i), (ii). Accordingly, ERISA does not even contemplate, much less require, that the employer must be involved in the administration of the benefit plan in order for it to be covered by ERISA.

B. The Imposition of Administrative Requirements Will Result in Tax Implications and Public Policy Concerns That Are Contrary to the Scheme Established by ERISA

A requirement that employers be involved in the administration of benefit plans under ERISA is grossly inconsistent with how employee benefit plans are implemented and administered. The overwhelming majority of employer-sponsored health care plans, which cover over 145 million employees and their dependents in the United States, are established simply through the purchase of insurance[4] with employer involvement generally limited (as in this case) to the selection of benefits, enrollment of participants, and payment of premiums.[5] The claims administration for the vast majority of those plans is conducted not by the employer, but by an insurer serving as a claims reviewer under ERISA § 503, 29 U.S.C. § 1133.[6]

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[4] Statistical Abstract of the United States (108 ed. 1988) 92.

The overwhelming majority of employers are simply not equipped to implement and administer the intricate, specialized and expensive mechanisms necessary to operate ERISA plans for their employees. Moreover, employers benefit greatly from the economies of scale available when plans are handled by third parties that administer large numbers of plans and participants.[7] If employers are required to engage more actively in the administration of plans the increased costs would be prohibitive for smaller employers, thereby creating a disincentive to the establishment of the plans. Ultimately, smaller employers will be unable to offer benefit plans to their employees.

More significantly, the tax consequences of the California Court of Appeal's decision completely negate the advantages previously enjoyed by employers offering plans similar to the ISI Plan. If plans such as the ISI Plan are not governed by ERISA, the preferential tax treatment that has been extended to providers and participants must be retroactively amended from the date of the plan's inception. I.R.C. §§ 402(a), 404(a) (1986). In general, treating employer contributions to benefit plans as taxable income under the current tax system "would dramatically reduce the provision of both pensions and health insurance." [8]

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[5] Scallet, *The Regulation of Multiple Employer Trusts: Past, Present & Future,* 61 Wash. U.L.Q. 359, 381 (1983) ("Scallet"). See also 1988 Foster Higgins Health Care Benefits Survey 23. (84% of employers insure their health care plans or self fund with stop-loss insurance coverage; for employers with less than 1,000 employees, 94% insure such plans or self fund with stop-loss insurance.)

[6] Scallet at 381, citing Buttelle, *Human Affairs Research Centers Employee Benefit Welfare Benefit Plans and Plan Sponsors in the Private Non-Farm Sector in the United States,* 1978-1979, Vol. IV, 43. Ninety-three percent of all employers, self-funded and insured alike, use an insurer or third party administrator for claims administration. 1988 Foster Higgins Health Care Benefit Survey 23.

[7] Mitchell, O., Andrews, E., *Scale Economies in Private Multiemployer Pension Systems,* Industrial and Labor Relations Review Vol. 34, No. 4 (July 1981.) Administrative expenses per participant are over ten times as high for plans with 100 participants as for those with 20,000 participants.

The decision below renders the provision of employee benefit plans a speculative proposition for both the employer and the employee. It is the declared policy of ERISA to protect the "continued well-being and security of millions of employees and their dependents . . . directly affected by [employee benefit plans]." ERISA § 2(a), 29 U.S.C. § 1001(a). From a public policy standpoint, this decision runs contrary to the ultimate interests of participants, employers and third-parties administering plans—interests fully protected under ERISA and completely jeopardized by the California courts.

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[8] Woodbury, S., *Current Economic Issues in Employee Benefits*, W.E. Upjohn Institute for Employment Research and Michigan State University, February, 1990. Pension provision is estimated to drop 50-64%, health insurance nearly 20%.

CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to examine the denial of a petition for review of the Supreme Court of California.

Respectfully submitted,

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August 20, 1990

APPENDIX

APPENDIX

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

IN BANK

S014928

TELLY KANAKIS *et al.*,
Appellants

v.

MUTUAL LIFE INSURANCE COMPANY OF NEW YORK *et al.*,
Appellants

Fourth Appellate District, Division Three, No. G006355

ORDER DENYING REVIEW AFTER JUDGMENT BY THE COURT OF APPEAL

[Filed May 23, 1990]

Appellants' petition for review DENIED.

/s/ Lucas
Chief Justice

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
FOURTH APPELLATE DISTRICT
DIVISION THREE

G006355
(Super. Ct. No. 441754)

TELLY KANAKIS *et al.*,
Plaintiffs and Appellants,

v.

THE MUTUAL LIFE INSURANCE COMPANY OF NEW YORK *et al.*,
Defendants and Appellants.

OPINION

[Filed Feb. 28, 1990]

APPEAL from a judgment of the Superior Court of Orange County, Claude M. Owens, Judge. Affirmed.

Pepper, Hamilton & Scheetz, Jesse D. Miller, Peter H. Mason and Wayne M. Smith for Defendants and Appellants.

Callahan, McCune & Willis and Robert W. Castleberry for Plaintiffs and Appellants.

Defendants Mutual of New York (MONY), Nancy A. Hiortdahl and Don Luhrson appeal a judgment upon a jury verdict against them for the sum of $171,344.61 compensatory damages and $500,000 in punitive damages. Plaintiffs Patricia and Telly Kanakis sued MONY and the individuals, alleging the wrongful conduct of the defendants in refusing to pay benefits due on MONY's policy for major medical coverage on the insureds, Kanakis. The trial court denied defendant's motion for judgment notwithstanding a verdict and a motion for new trial and the plaintiffs' motion for attorney's fees. Defendants appeal this judgment; plaintiffs cross-appeal from the denial of their motion for attorney's fees.

MONY contends on appeal the insurance coverage provided to Telly and Patricia Kanakis by her employer was an employee benefit plan governed by the Employees' Retirement Income Security Act (ERISA). If this be true the Kanakises' common law and statutory causes of action are preempted—not cognizable in the state court system. Subsidiary issues involve MONY's claims the trial-court improperly instructed the jury that the employer's intent to establish an ERISA plan was a necessary element to create such an ERISA plan, and that MONY's coordination of benefits provision (COB) was ambiguous as a matter of law. Finally, MONY contends the jury's award of punitive damages and for damages for intentional infliction of emotional distress is not supported by substantial evidence.

FACTS

Plaintiff Telly Kanakis (Telly) was involved in a serious motorcycle accident on November 29, 1983. The result was a lengthy stay in the UCI Medical Center with numerous broken bones. At the time of trial, he still had a rod in his left femur put there during the first hospitalization. He had sustained fractures to his left leg including his tibia, fibula and femur, nerve damage to his left arm, dislocation of jaw, left wrist and right finger. He had severe paralysis of the left arm for five months after the accident. Amputation was contemplated. He was in bed for approximately five months after the accident, in a wheelchair for three months, and could not sleep without medication due to pain. He had no income from the time of the accident from November 1983 until September 1984.

As a result of the injuries sustained, he saw approximately 20 doctors. Hospital and medical expenses incurred by him amounted to some $36,897.69. At time of trial, he had problems in his arm and leg. He could not run nor go up too many stairs. Marital separation resulted from the chaos following the accident. Lawsuits were threatened. He was in need of future medical work to be done on his jaw, and removal of the rod from his left knee.

At the time of the accident, Telly was covered by two medical insurance policies, one, through his own employment (Benefit Fund) and a second as dependent on his wife's employer's medical insurance plan (MONY). Benefit Fund's policy, by its express terms, required an assignment of any monies received from third parties liable before Benefit Fund would pay any medical claim. Telly elected not to execute a third party assignment to Benefit Fund; thereupon Benefit refused to pay any medical benefits.

Telly withdrew the claim against Benefit Fund and sought reimbursement only from MONY and the responsible third party tortfeasor. He received a settlement in the amount of $50,000 from the tortfeasor. Neither Benefit Fund nor MONY has paid Telly or Patricia any money for the injuries and the medical expenses incurred in the accident.

Telly claimed MONY was liable because he was insured by two different insurance companies, premiums had been paid to both insurance companies, and he had been insured by MONY before he became insured by Benefit Fund. MONY's position throughout the trial was that it did not pay any claims because Telly's claims had to be first submitted to Benefit Fund and payments made by Benefit Fund before any obligation on the part of MONY arose. There were no payments by MONY between the date of the accident and the time of the trial in 1987, a period of approximately four years.

Telly's wife, Patricia, worked for Insurance Systems, Inc. (Caresystems) as a sales representative selling computer hardware. MONY was her health insurer. At her request, Telly was covered as a dependent under the policy. Premiums ($50) were deducted from her paycheck for her husband's coverage every two weeks. These premiums were paid from July 1983 to date of the accident in November 1983. She continued to carry him on the MONY policy after the accident. She was not told the insurance policy from MONY was under ERISA rules. The book she received from her employer did not mention the word ERISA. The subject had never been discussed with her.

Patricia made her first claim in November 1983 at the UCI Medical Center. She then learned about MONY coverage as well as the Benefit Fund coverage. She talked to defendant Hiortdahl (MONY's service specialist) on different occasions and received a number of letters from her. Hiortdahl adamantly told Patricia MONY was not going to pay on the claim until Benefit first paid its portion. Patricia submitted all claims to both insurance companies with the hope and expectation that the medical bills would be paid.

Hiortdahl knew the general purpose of a COB was to provide, as between the two carriers, 100 percent coverage; the primary carrier would pay its benefits and MONY would pay whatever the primary carrier did not pay. She did not know in November 1983 whether MONY was an ERISA policy; the particular document referring to ERISA was not in the MONY file. Hiortdahl sent out additional inquiries to the Kanakises but did not make any inquiry of Benefit Fund until September 21, 1984. She never talked to anyone at Benefit

Fund. She never investigated Benefit Fund's coordination of benefits (COB) provisions.

The COB provision in the Benefit Fund policy was unique in this respect. *It applied only to the dependent's coverage* in that plan. It did not apply to the primary insured's (employee's) coverage. By its express language the COB provision did not apply to Telly, the employee. While Exhibits 4 and 5 of Benefit Fund's policy required Telly to assign certain rights before Benefit Fund would take any further action, there was no similar assignment provision in the MONY policy.

Defendant Luhrson, an employee of MONY, also knew Benefit Fund had not made payments to Kanakis due to its assignment requirement. In the face of these facts, MONY contended there was never any denial of benefits. They charged Telly was the cause for non-payment, by reason of his failure to first make the assignment to Benefit Fund.

The trial court found the COB provision in the Benefit Fund policy was ambiguous as applied to the facts of this case and so instructed the jury. The reason: The Coordination Of Benefits provision in the Benefit Fund policy did not apply to Telly because he was not a "dependent" and was thus excluded by the express terms of the provision. In contrast, the COB provisions in the MONY policy stated the insurance company which covered an insured other than as a dependent would be required to pay accrued expenses before an insurance company also covering the insured as a dependent would be obligated to pay any claims. MONY's COB provision further declared MONY's obligation to pay in this situation would be reduced not only by the amount actually paid by the other insurance company but also by any benefits the insured would have obtained had the claim been duly made therefor. MONY's counsel urged Telly was covered by Benefit Fund COB despite his exclusion as the policy "employee." If MONY's argument is sound, the trial judge's ruling was in error.

MONY contended that Telly's motive in refusing to execute the assignment was to obtain a double recovery from both MONY and the third party tortfeasor, since MONY did not require any such assignment of recovery from a third party tortfeasor. MONY claimed the $50,000 settlement with the third party tortfeasor exceeded the total medical expenses incurred by Telly as a result of the accident, despite the fact there was no allocation in the settlement award as between medical expenses and the general and other special damages.

After the four-day trial, the jury answered questions in specially prepared verdict forms. The jury found that (1) that MONY's insurance policy was not governed by Employee's Retirement Income Security Act of 1974, 29 United States Code section 1001 et seq. (ERISA); (2) the breach of contract by MONY was the proximate cause of the damage to the Kanakises; (3) MONY had breached the implied covenant of good faith and fair dealing; (4) MONY had violated Insurance Code section 790.03(e); (5) MONY had engaged in outrageous conduct with an intent to cause, and with disregard for the probability of causing, emotional distress to the Kanakises; and (6) the defendants were negligent. The jury awarded Telly $50,000 and Patricia $75,000 in tort damages, assessed $36,897.69 for breach of contract, and awarded punitive damages in the sum of $500,000.

DISCUSSION

I

MONY contends the jury erred as a matter of law in finding their insurance plan was not preempted by ERISA. If the MONY insurance policy is an "ERISA" plan, then federal statute and case law preempts plaintiffs' claims made herein and precludes their filing of

California recognized statutory or common law claims against MONY. (*Commercial Life Ins.* v. *Superior Court* (1988) 47 Cal.3d 473, 483; *Rizzi* v. *Blue Cross of Southern California* (1989) 206 Cal.App.3d 380, 392.)

"The existence [or lack] of an ERISA plan is a question of fact to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person." (*Kanne* v. *Connecticut General Life Ins. Co.* (9th Cir. 1988) 859 F.2d 96, 98; see also *Credit Managers Assoc.* v. *Kennesaw Life & Acc. Ins. Co.* (9th Cir. 1987) 809 F.2d 617, 625; *Donovan* v. *Dillingham* (11th Cir. 1982) 688 F.2d 1367, 1373.) This is a preliminary and fundamental question to be determined before the preemption doctrine applies to preclude state court jurisdiction. Kanakis concedes if the plan is an ERISA plan, under the holding of the California Supreme Court in *Commercial Life Ins. Co.* v. *Superior Court, supra,* 47 Cal.3d 473, 484-485 and the United States Supreme Court in *Pilot Life Ins. Co.* v. *Dedeaux* (1987) 481 U.S. 41, 57 their claim is preempted and cannot be brought in the state court.[1] Thus, the question of whether the policy here is governed by ERISA takes on a vital importance to the Kanakises.

The question of whether the MONY insurance provided was an ERISA plan was submitted to the jury for a factual determination. The jury found it was not an ERISA plan. If substantial evidence supports that finding, it must be upheld.

The ERISA law is in 29 United States Code sections 1001 et seq. Congressional findings and declarations of policy are set forth in 29 United States Code section 1001. Congress recognized in the nationwide proliferation of employee benefit plans, certain abuses resulted in employee losses of retirement benefits. Thus, the need arose for Congress to establish certain minimal standards to assure the "equitable character" of such plans and their financial "soundness." (29 U.S.C. § 1001, subd. (c); *Commercial Life Ins. Co.* v. *Superior Court, supra,* 47 Cal.3d at p. 476.)

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[1] An exception exists for claims under 29 United States Code section 1132, subdivision (e)(1) granting concurrent jurisdiction to state courts for actions under (a)(1)(B) of this section. (*Commercial Life Ins. Co.* v. *Superior Court, supra,* 47 Cal.3d at p. 485.)

The act protects participants of the employees benefit plans by requiring disclosure to participants and by establishing standards of conduct and fiduciary duties. ERISA provides for remedies, sanctions and ready access to the federal courts. (29 U.S.C., § 101, subd. (b).) ERISA also imposes upon benefit plans various substantive requirements relating to participation, funding and vesting. *However, it contains almost no federal regulation of the substantive terms of the benefit plans.* (*Metropolitan Life Ins. Co.* v. *Massachusetts* (1985) 471 U.S. 724, 732.)

ERISA contains a broad preemption clause which provides: "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975." (29 U.S.C., § 1144, subd. (a).) The clause has as its purpose to protect employers from conflicting and inconsistent state and local regulations of employee benefit plans. (*Shaw* v. *Delta Airlines* (1983) 463 U.S. 85, 99.) The breadth of the clause is qualified by the savings clause which provides: "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." (29 U.S.C., § 1144, subd. (b)(2)(A).)

ERISA defines a "employee welfare benefit plan" as including "any *plan, fund, or program* which was heretofore or is hereafter *established or maintained by an employer or by an employee organization, or by both,* to the extent that such *plan, fund, or program* was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical or hospital care or benefits . . . ." (29 U.S.C., § 1002, subd. (1), emphasis added.) ERISA applies to "any employee benefit plan if it is established or maintained—[¶] (1) by any employer engaged in commerce or in any industry or activity affecting commerce; . . ." (29 U.S.C., § 1003, subd. (a).)

II

ERISA preempts only *plans*, not *benefits.* Nowhere in the statute are the terms treated as equivalent. (*Fort Halifax Packing Co.* v. *Coyne* (1987) 482 U.S. 1, 7-8, 12-15.) From *Fort Halifax* we gain this insight as to the requirements for and the nature of an ERISA plan. In *Fort Halifax* the Supreme Court considered a Maine statute requiring employers to provide a one-time severence payment to employees in the event of plant closing. The Supreme Court concluded it was not an employee benefit *plan.*

The Supreme Court observed that under the administrative realities of an employee benefit *plan*: "An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements." (*Id.* at p. 9.)

The Supreme Court further pointed out that in any preemption analysis, " ' "[T]he purpose of Congress is the ultimate touchstone." ' " (*Id.* at p. 8.) Concerning congressional intent, the Supreme Court stated, "*The* *third answer to appellant's argument is that the Maine statute not only fails to implicate the concerns of ERISA's pre-emption provision, it fails to implicate the regulatory concerns of ERISA itself.* The Congressional declaration of policy, codified at 29 U.S.C., § 1001, states that ERISA was enacted because Congress found it desirable that 'disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of [employee benefit] plans.' . . . *The focus of the statute thus is on the administrative integrity of benefit plans—which presumes that some type of administrative activity is taking place.*" (*Id.* at p. 15, emphasis added.)

The Supreme Court further declared, "The foregoing makes clear both why ERISA is concerned with regulating benefit 'plans,' and why the Maine statute does not establish one. Only 'plans' involve administrative activity potentially subject to employer abuse. The obligation imposed by Maine generates no such activity. There is no occasion to determine whether a 'plan' is 'operated' in the interest of its beneficiaries, *because nothing is 'operated.'* No financial transactions take place that would be listed in an annual report, and no further information regarding the terms of the severance pay obligation is needed because the statute itself makes these terms clear. It would make no sense for pre-emption to clear the way for exclusive federal regulation, for there would be nothing to regulate. *Under such circumstances, pre-emption would in no way serve the overall purpose of ERISA.*" (*Id.* at p. 16, emphasis added.)

From the foregoing we conclude: The focus of ERISA is on the administrative integrity of *employers'* benefit plans. Thus ERISA preemption presumes some specie of administrative activities by the employer is taking place. (*Fort Halifax Packing Co.* v. *Coyne*, *supra*, 482 U.S. at pp. 15-16.) The existence or lack of existence of an ERISA plan depends upon the extent to which the employer is involved in the administration of the benefit program so as to implicate the concerns which gave rise to ERISA.

III

What is an employer plan under ERISA is illustrated in *Kanne* v. *Connecticut General Life Ins., Co., supra,* 859 Fed.2d 96, and cited by the California Supreme Court as an authoritative statement of the federal ERISA law in *Commercial Life Ins. Co.* v. *Superior Court, supra,* 47 Cal. 3d 473, 482, 483. The plan brochure, introduced by the insurance company, described the plan as an ERISA plan. Associated Builders and Contractors (ABC) was an employer group to which the employer (Harlo Carpets) belonged, and was described as the administrator of the plan. The employer subscribed to a group health insurance plan administered by ABC. Pursuant to the requirements of ERISA, the plan was established as a trust entity, called the ABC Trust. It purchased a policy of group health insurance from Connecticut General. Kanne was an employee of Harlo Carpets and covered by the insurance policy. The *Kanne* court observed the Connecticut General brochure describes the plan as an ERISA plan, "*evidencing the intent of ABC to create an ERISA plan.*" (*Kanne* v. *Connecticut General Life Ins. Co., supra,* 859 F.2d 96, 99, emphasis added.)

It concluded ABC, the employers' group, was an administrator of the plan subject to ERISA regulations. The court also pointed out "[*a*] *bare purchase of insurance, without any of the above elements present, does not by itself constitute an ERISA plan (although it may be evidence of the existence of an ERISA plan).*" (*Kanne* v. *Connecticut General Life Ins. Co., supra,* 859 F.2d 96, 99, emphasis added; see also *Donovan & Donovan* v. *Dillingham, supra,* 688 F.2d 1367, 1375; *Martori Bros. Distributors* v. *James-Massengale* (9th Cir. 1986) 781 F.2d 1349, 1358.)

Contrast the undisputed facts here. The only responsibilities and duties of the employer of Patricia Kanakis was to have the MONY applications filled out for each employee, to name the beneficiaries on the life insurance, to inform the insurance company who the employees were, to pay the premiums directly to the company, to reconcile the statements regularly, and to act as a conduit for employee questions or problems regarding the policies.

There is a total lack of evidence here as to the nature of the employer's administrative participation in any plan. Patricia's employer simply obtained the medical benefits for its employees through the purchase of the MONY policy. It distributed the booklets to its employees describing the benefits and claims procedures.

There is no evidence in this record suggesting *MONY*, the insurance company, was an employer or employer group or employee group. Its function was to supply an insurance policy. The sole function of Patricia's employer was to finance the plan, excepting of course where the dependent, Telly, was involved. Fifty dollars a month was deducted from Patricia's salary to cover Telly's insurance. There is no evidence of a trust, an employer or employer group, or an employee group administering the plan as in *Kanne*.

ERISA defines an employer as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." (29 U.S.C., § 1002, subd. (5).) MONY is not an employer as defined that section of ERISA.

IV

The existence of an ERISA plan depends upon the extent to which the employer is involved in the administration of the benefit program so as to implicate the concerns which gave rise to ERISA. Here, *there is no evidence that Patricia's employer made any commitment to pay or regulate or administer benefits.* (*Fort Hali-*

fax Packing Co. v. *Coyne, supra,* 482 U.S. at p. 15.) *Its role was limited to paying the policy premiums.* As the United States Supreme Court stated in *Fort Halifax,* "*To do little more than write a check hardly constitutes* the operation of a benefit *plan.*" (*Id.* at p. 12, emphasis added.)

Patricia's employer did not undertake the administrative responsibilities such as the determination of eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments or keeping appropriate records in order to comply with applicable reporting procedures. (*Fort Halifax Packing Co.* v. *Coyne, supra,* 482 U.S. at p. 15.) Substantive evidence supports the jury's determination this was not an ERISA plan. The regulatory concerns of ERISA were not implicated by the act of purchasing insurance. There was no employer administered plan; therefore, there was no potential for employer abuses in such areas as self-dealing, imprudent investments and misappropriations. The congressional purpose expressed in ERISA was not implicated.

Based upon the uncontested facts the Kanakises' health insurance benefit procured through MONY was not a plan within the meaning of ERISA. Plaintiffs' causes of action were therefore not preempted by ERISA.

V

MONY next contends the trial court erred in instructing the jury an "intent" was required in order to form an ERISA plan. Case authority supports such an instruction. (*Wayne Chemical, Inc.* v. *Columbus Agcy. Serv. Corp.* (7th Cir. 1977) 567 F.2d 692.) The *Wayne* court held, "An employer does not become a participant in, or establish or maintain, a plan by applying for insurance and paying premiums for what it understands to be insurance without any knowledge that the plan exists. *Establishing, maintaining, or participating in a* *plan requires an intent, . . .*" (*Id.* at p. 699, emphasis added; see also *Taggart* v. *Life & Health Benefit Administration* (5th Cir. 1980) 617 F.2d 1208, 1211-1212 [holding that a securities employer's trust was not an employee welfare benefit plan within the meaning of ERISA because neither the Taggart Corporation nor any other employer participated in the operation or administration of it].) In *Kanne* v. *Connecticut General, supra,* 859 F.2d 96, the federal court pointed out that, "*The plan brochure submitted by Connecticut General as an exhibit at trial describes the plan as an ERISA plan, evidencing the intent of ABC to create an ERISA plan.*" (*Id.* at p. 99, emphasis added.)

We hold that as a prerequisite to the creation and the existence of an ERISA plan, the employer must intend to create and to participate in such a plan. Such intent may be found in acts as well as words. (*Kanne* v. *Connecticut General, supra,* 859 F.2d at p. 99.)

Contrary authorities are cited by MONY. We do not choose between these competing rules for we have determined on the basis of undisputed facts that the act of the employer in paying an insurance premium does not implicate the congressional concerns which gave rise to the ERISA regulations and preemption doctrine.

If the instruction was error, it produced no prejudice and no cause for reversal. In light of our holding concerning the total lack of evidence to establish the existence of an ERISA employer's "plan" preemptive of state law, we find it unnecessary to address MONY's sound but irrelevant contention concerning the preemption of section 790.03 claims by ERISA. (See *Commercial Life Ins.* v. *Superior Court, supra,* 47 Cal.3d at pp. 481-485.)

The trial court ruled, "The MONY Policy is ambiguous as to whether or not the benefits of the Benefit Fund policy are to be determined before the benefits of the MONY policy . . . because MONY's coordination of benefit . . . provision . . . that defines priority between the policies . . . applies only when the other policy has a provision which coordinates its benefits with the MONY plan . . . and that the Benefit Fund policy does not appear to have such a provision."

The trial court further found Benefit Fund's COB provision "expressly applies only to 'dependents' and 'Telly Kanakis was not a dependent under the Benefit Fund policy.' " He was the insured *employee* and therefore "MONY was obligated to pay plaintiff the benefit to which he was entitled."

The trial judge's reasoning was based upon his examination of two certificates of insurance. He concluded the Benefit Fund's COB provision applied only to a *dependent* of Telly Kanakis; therefore there could be no coordination of benefits provision of the plan to coordinate with MONY's insurance policy. The trial judge's interpretation of the contracts was factually and legally correct. Benefit Fund's COB policy does not apply to Telly; therefore MONY's COB provision had no basis for a coordination of benefits with another policy.[2]

VII

In support of its assertion that the COB provision should have been applied to Telly, thus requiring him to resort to his employer's policy first, MONY argues Telly is in effect getting a double recovery in that he settled his personal injury case for $50,000 with the third party tortfeasor. This assertion rests upon speculation, not fact. Telly's Hospital and medical insurance expenses here amounted to some $36,897.69. Telly sustained fractures of his left leg—tibia, fibula, and femur—and had nerve damage to his left arm as well as dislocation of his jaw, left wrist and right finger. Five months after the accident he still had a severe paralysis of his left arm, he was in bed for five months after the accident and in a wheelchair for three months after that, unable to move without help of his wife. He had a rod in his leg from the accident at the time of trial. It was not removed within a year of the accident because of Telly's financial inability. He could not raise his left arm at time of trial. He has no income whatsoever from the time of the accident until September. To argue that there will be a double recovery is again without factual support. This settlement was made without allocation as to future medical expenses, pain and suffering, loss of wages, etc. After applying $36,000 of the $50,000 recovery to medical costs incurred, there remained less than $14,000 for loss of earnings, pain, suffering and the permanent disability sustained by Telly Kanakis. This argument for reversal is without merit in fact or law.

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[2] At the hearing on appeal, counsel for MONY made a most skillful argument to the effect that Kanakis was covered by the Benefit Fund COB. If there be merit to counsel's argument, the net result is an ambiguity, as the trial court found and resolved against the insurer.

VIII

MONY contends substantial evidence does not support the jury award of punitive damages. Witness Luhrson claimed on behalf of MONY there was never any denial of benefits, yet he admitted the claim had not been paid. It was still unpaid after four years. An expert on bad faith testified the unreasonable delays in processing constitute bad faith. He also testified if the insurance company needs information which is reasonably available to it in order to process a claim, the company has an affirmative obligation to obtain that information. It cannot sit back and wait for the insured to provide it. Luhrson had been informed (by the Kanakises' attorney) that no claim would be filed against Benefit Fund.

In *Egan* v. *Mutual of Omaha Insurance* (1979), 24 Cal. 3d 809, the Supreme Court held that where an insurer unreasonably withholds payments due under an insurance policy, recovery of punitive damages may be based upon the insurer's failure to investigate the insured's claim properly before denying it. (*Id.* at pp. 817, 819.) An insurance company cannot reasonably and in good faith deny payments without first thoroughly investigating the foundation for its denial. MONY employees showed no interest in ascertaining whether their COB contention vis-a-vis Benefit Fund's clause had any validity in fact.

It is reasonable to deduce that MONY refused to pay the benefits due under its policy because of its interpretation of its COB provision. The trial judge effectively disposed of this COB defense by pointing out its nonapplicability to Telly, who was an employee and not a dependent. By a simple reading of Telly's insurance contract, MONY could have been equally enlightened. This the MONY's employees did not do. The award of punitive damages was justified.

IX

The Kanakises' claim for attorney's fees is without merit. *Brandt* v. *Superior Court* (1985), 37 Cal. 3d 813 held, "When an insurer's tortious conduct reasonably compels the insured to retain an attorney to obtain the benefits due under a policy, it follows that the insurer should be liable in a tort action for that expense. The attorney's fees are an economic loss—damages—proximately caused by the tort." (*Id.* at p. 817.) However the *Brandt* court established the procedural framework within such an award should be assessed. Said the *Brandt* court: "Since the attorney's fees are recoverable as damages, the determination of the recoverable fees must be made by the trier of fact unless the parties stipulate otherwise." (*Id.* p. 819.) Here there was no presentation of evidence, no request to the jury, nor any jury instructions offered on the issue of attorney's fees.

The trial court properly denied the request for attorney's fees under *Brandt's* procedural requirements.

The judgment is affirmed.

/s/ Staniforth
STANIFORTH, J.*

WE CONCUR:

/s/ Crosby
CROSBY
Acting P.J.

/s/ Sonenshine
SONENSHINE
J.

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* Retired Associate Justice of the Court of Appeal sitting under assignment by the Chairperson of the Judicial Council.

VERIFICATION

STATE OF CALIFORNIA, COUNTY OF

I have read the following ———————————————— ———————————————— and know its contents.

☒ CHECK APPLICABLE PARAGRAPH

☐ I am a party to this action. The matters in the foregoing document are true of my own knowledge except as to those matters which are stated on information and belief, and as to those matters I believe to be true.

☐ I am ☐ an Officer ☐ a partner———— ☐ a———— of————————————————————————, a party to this action, and am authorized to make this verification for and on its behalf, and I make this verification for that reason. ☐ I am informed and believe and on that ground allege that the matters stated in the foregoing document are true. ☐ The matters stated in the foregoing document are true of my own knowledge except as to those matters whoch are stated on information and belief, and as to those matters I believe them to be true.

☐ I am one of the attorneys for ————————————, a party to this action. Such party is absent from the county of aforesaid where such attorneys have their offices, and I make this verification for and on behalf of that party for that reason. I am informed and believe and on that ground allege that the matters stated in the foregoing document are true.

Executed on ——————, 19—, at ————————, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

————————————	————————————
Type or Print Name	Signature

PROOF OF SERVICE
1013A (3) CCP Revised 5/1/88

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in the county of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is: 700 South Flower Street, Los Angeles, California 90017.

On 4/6/1990, I served the foregoing document described as PETITION FOR REVIEW on all interested parties in this action

☒by placing the true copies thereof enclosed in sealed envelopes addressed as stated on the attached mailing list:

☐by placing ☐ the original ☐ a true copy thereof enclosed in sealed envelopes addressed as follows:

☒BY MAIL

☐*I deposited such envelope in the mail at ———, California.

The envelope was mailed with postage thereon fully prepaid.

☒As follows: I am "readily familiar" with the firm's practice of collection correspondence for mailing. Under that practice it would be deposited with U.S. postal service on that same day with postage thereon fully prepaid at Los Angeles, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage under meter date is more than one day after date of deposit for mailing in affidavit.

Executed on 4/6/1990, at Los Angeles, California.

☐ **(BY PERSONAL SERVICE I delivered such envelope by hand to the offices of the addressee.

Executed on ———, 19—, at ———, California.

☒ (State) I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

☒ (Federal) I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made.

Loraine Brule	[Illegible]
Type or Print Name	Signature

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COURT OF APPEAL—STATE OF CALIFORNIA
FOURTH APPELLATE DISTRICT
DIVISION THREE

G006355
Orange County No. 441754

KANAKIS, TELLY

v.

MUTUAL LIFE INSURANCE CO. OF NEW YORK

[Filed Mar. 22, 1990]

THE COURT:

The petition for rehearing is DENIED.

/s/ Staniforth
STANIFORTH
Justice*

We Concur:

/s/ Crosby
Acting Presiding Justice

/s/ Sonenshine
Justice

cc: Orange County Clerk
All Counsel

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* Retired Associate Justice of the Court of Appeal sitting under assignment by the Chairperson of the Judicial Council.

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SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF ORANGE

Case No. 44 17 54

TELLY KANAKIS and PATRICIA KANAKIS
Plaintiffs
v.
THE MUTUAL LIFE INSURANCE COMPANY OF NEW YORK *et al*
Defendants.

JUDGMENT ON SPECIAL VERDICT

[Filed Sep. 18, 1987]

This action came on regularly for Trial on September 2, 1987 in Department 26 of the above entitled court, the Honorable Claude Owens, Judge presiding; the plaintiffs appearing by attorney Robert W. Castleberry and the defendants appearing by attorneys Brian A. Pierk and George A. Tackabury.

A jury of twelve persons was impaneled and sworn. Witnesses were sworn and testified. After hearing the evidence and arguments of counsel, the jury was duly instructed by the court and the cause was submitted to the jury with directions to return a verdict on special issues. The jury deliberated and thereafter returned into court with its verdict consisting of the special issues submitted to the jury and the answers given thereto by the jury, which said verdict was in words and figures as follows, to-wit:

We the jury in the above-entitled case, find the following special verdict on the questions submitted to us:

Question No. 1: Was there an ERISA plan of Insurance Systems Incorporated which provided medical benefits for the plaintiffs?

Answer "yes" or "no".

Answer: No

If you answer Question No. 1 "yes" sign and return the verdict but do not answer any other questions.

If you answer Question No. 1 "no", then answer Questions 3 through 7.

Question No. 3: Breach of Contract

Was the breach of the insurance contract by MONY a proximate cause of damage to plaintiffs?

Answer "yes" or "no".

Answer: yes

Question No. 4: Breach of Covenant of Good Faith and Fair Dealing.

4.A. Did Defendant MONY breach its implied obligation to Plaintiffs of good faith and fair dealing on the insurance policy?

Answer "yes" or "no"

Answer: yes

If you answer Question 4.A "no", then do not answer Question 4.B and go to Question 5.

If you answer Question 4.A "yes", then answer Question 4.B before you answer Question 5.

4.B. Was said breach a proximate cause of damage to Plaintiffs?

Answer "yes" or "no".

Answer: yes

Question No. 5: Breach of Insurance Code Section 790.03.

5.A. Did Defendants breach one or more of the provisions of California Insurance Code Section 790.03?

Answer "yes" or "no".
Answer: yes

If you answer Question 5.A "no", then do not answer Question 5.B and go to Question 6.

If you answer Question 5.A "yes", then answer Question 5.B before you answer Question 6.

5.B. Was said breach a proximate cause of damage to Plaintiffs?

Answer "yes" or "no".

Answer: yes

Question No. 6: Intentional Infliction of Emotional Distress.

6.A. Did Defendants engage in outrageous conduct with intent to cause, or with reckless disregard of the probability of causing, emotional distress to Plaintiffs?

Answer "yes" or "no".

Answer: yes

If you answer Question 6.A "no", then do not answer Question 6.B and go to Question 7.

If you answer Question 6.A "yes", then answer Question 6.B before you answer Question 7.

6.B. Was such conduct of the Defendants a proximate cause of damage to Plaintiffs?

Answer "yes" or "no".

Answer: yes

Question No. 7: Negligence.

7.A. Were any of the Defendants negligent?

Answer "yes" or "no".

Answer: yes

If you answer Question 7.A "yes", then answer Question 7.B.

If you answer Question 7.A. "no", then do not answer Question 7.B and instead go directly to the "instructions" immediately following Question 7.B.

7.B. Was such negligence a proximate cause of damage to Plaintiffs?

Answer "yes" or "no".

Answer: yes

Instructions: If your answers to Questions 3, 4.B, 5.B, 6.B and 7.B are all "no", or if you gave no answers to those questions, then sign and return the verdict and do not answer any further questions.

If you answer any of Questions 4.B, 5.B, 6.B, or 7.B "yes", then proceed to the remaining questions and answer them, if applicable, according to the instructions provided at the beginning of each question.

Question No. 9: If your answer to Questions 4.B, 5.B, 6.B, and 7.B is "no", then do not answer Question 9, 10 or 11 and sign and return this verdict. If your answer to Questions 4.B, 5.B, 6.B and 7.B, or any of them, is "yes", then answer the following questions:

9.A. What is the total amount of emotional distress damages suffered by Plaintiff Telly Kanakis as a proximate result of said conduct by Defendants?

Answer: $50,000.00

If you answer Question 9.A "no damage", then do not answer Questions 9.B through 9.D and instead go directly to Question No. 10. If you answer Question 9.A with an amount of money, then answer Question 9.B.

9.B. Was Plaintiff Telly Kanakis negligent?

Answer "yes" or "no"

Answer: No

If you answer Question 9B. "no", then go directly to 10.

If you answer Question 9.B "yes", then answer Question 9.C.

9.C. Was the negligence of Plaintiff Telly Kanakis a proximate cause of the emotional distress damage to Telly Kanakis?

Answer "yes" or "no".

Answer: ——

If you answer Question 9.C "no", then do not answer Question 9.D and instead go to Question 10.

If you answer Question 9.C "yes", then answer Question 9.D.

9.D. Assuming that 100% represents the total negligence which was the proximate cause of emotional distress damages of Plaintiff Telly Kanakis, what percentage of this 100% is due to the contributory negligence of Plaintiff Telly Kanakis and what percentage of this 100% is due to the negligence of the Defendants?

Answer: (a) To Plaintiff Telly Kanakis N/A%

Answer :(b) to Defendants N/A%

TOTAL 100%

Question 10: If your answer to Question 4.B, 5.B, 6.B and 7.B is "no", then do not answer Questions 10 or 11 and sign and return this verdict. If your answer to Question 4.B, 5.B, 6.B, and 7.B, or any of them, is "yes", then answer the following questions:

10.A. What is the total amount of emotional distress damages suffered by Plaintiff Patricia Kanakis as a proximate result of said conduct by Defendants?

Answer: $75,000.00

If you answer Questions 9.A and 10.A "no damage", then do not answer Questions 10.B through 10.D and sign and return the verdict.

If you answer Question 9.A with an amount of money and Question 10.A "no damage", then answer Question 11.

Regardless of how you answer Question 9.A, if you answered Question 10.A with an amount of money, then answer question 10.B.

10.B. Was Plaintiff Patricia Kanakis negligent?

Answer "yes" or "no"

Answer: No

If you answer Question 10.B "no", then answer Question 11.

If you answer Question 10.B "yes, then answer Question 10.C.

10.C. Was the negligence of Plaintiff Patricia Kanakis a proximate cause of the emotional distress damages to Patricia Kanakis?

Answer "yes" or "no:

Answer: N/A

If you answer Question 10.C "no", then do not answer Question 10.D, but proceed to answer Question 11.

If you answer Question 10.C "yes", then answer Question 10.D.

10.D. Assuming that 100% represents the total negligence which was the proximate cause of emotional distress damages of Plaintiff Patricia Kanakis, what percentage of this 100% is due to the contributory negligence of Plaintiff Patricia Kanakis and what percentage of this 100% is due to the negligence of Defendant?

Answer: (a) To Patricia Kanakis N/A%

Answer: (b) To Defendants N/A%
TOTAL 100%

10.E. You should answer Question 11 at this time only if both of the following two conditions have been met:

1. You answer Questions 4.B, 5.B, or 6.B., or any of them, "yes" and

2. You answer Questions 9.A or 10.A with an amount of money.

If both of the above two conditions have been met, you should sign and return the verdict and do not answer Question No. 11.

Question No. 11: If your answer to Questions 4.B, 5.B and 6.B is "no", then do not answer Question 11 and sign the verdict. If your answer to Question 4.B, 5.B or 6.B, or any of them, is "yes", then answer the following Question:

11.A. Were the Defendants guilty of malice in the conduct on which you base your finding of liability?

Answer "yes" or "no:

Answer: yes (10-2.)

If you answer Question 11.A. "no", then sign and return Question 11.B.

11.B. What amount of punitive damages do you award against the Defendants?

Answer: $500,000.00

DATED: September 16, 1987

Edward Zepfel
Foreman/Forewoman

It appearing that by reason of said special verdict:

Plaintiff Telly Kanakis is entitled to $50,000 in emotional distress damages against Defendant Mutual Life Insurance Company of New York, Nancy A. Hiortdahl and Donald Luhrsen.

Plaintiff Patricia Kanakis is entitled to $75,000 in emotional distress damages against Defendants Mutual Life Insurance Company of New York, Nancy A. Hiortdahl and Donald Luhrsen.

Pursuant to stipulation of counsel, Plaintiffs Telly and Patricia Kanakis are entitled to breach of contract damages in the amount of $36,897.69, against Defendant Mutual Life Insurance Company of New York.

Plaintiffs Telly and Patricia Kanakis are entitled to $500,000.00 in punitive damages against Mutual Life Insurance Company of New York, Nancy A. Hiortdahl and Donald Luhrsen. All of the above with interest thereon as allowed by law.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED:

That Plaintiff Telly and Patricia Kanakis have judgment against Defendants Mutual Life Insurance Company of New York, Nancy A Hiortdahl and Donald Luhrsen for the sum of $500,000.00, with interest thereon at the legal rate, ten per cent per annum (10%) commencing June 23, 1987 and continuing until entry of this judgment.

In addition, that Plaintiffs Telly and Patricia Kanakis have judgment against Defendant Mutual Life Insurance Company of New York in the amount of $36,897.69 per stipulation with interest thereon at the legal rate, seven percent (7%) commencing November 19, 1984 and continuing until entry of this judgment.

In addition, that Plaintiff Telly Kanakis have judgment against Defendants Mutual Life Insurance Company of New York, Nancy A. Hiortdahl and Donald Luhrsen for the sum of $50,000.00 with interest thereon at the legal rate, ten percent per annum (10%) commencing June 23, 1987 and continuing until entry of this judgment.

In addition, that Plaintiff Patricia Kanakis have judgment against Defendants Mutual Life Insurance Company of New York, Nancy Hiortdahl and Donald Luhrsen in the amount of $75,000.00 with interest thereon at the legal rate, ten percent per annum (10%) commencing June 23, 1987 and continuing until entry of this judgment.

That Plaintiffs Telly and Patricia Kanakis recover costs, disbursements in the amount of $———.

DATED: 9-18-87

/s/ Claude Owens
CLAUDE OWENS
Judge of the Superior Court
(Assigned)

TITLE I

PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE A—GENERAL PROVISIONS

FINDINGS AND DECLARATION OF POLICY

Sec. 2. (a) The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interest of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) It is hereby further declared to be the policy of this Act to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

DEFINITIONS

Sec. 3. For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing

for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions).

* * * *

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

* * * *

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

* * * *

(16) (A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, commitment, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

* * * *

EXCERPTS OF TRIAL TRANSCRIPT

* * * *

[320] Q Doesn't self-insurance have anything of that nature?

A No.

Q Do you have anything to do with obtaining insurance benefits for your employees or employees of care?

A Yes, I do.

Q What do you have to do as far as that is concerned?

A My responsibility is in the acquisition of insurance policies for employees and for the company as a whole, I deal with an insurance broker who actually handles the one-on-one negotiating with the companies.

I rarely if ever have communications with the company, with the insurance company.

Q Do you try and get good benefits for your employees and you rely on your broker to go out and check the marketplace and—

A Yes, my broker is an independent broker and [321] represents companies and brings to me a proposal each year or in the case of markets where there is volatile changes, brings me information several times a year in order to see what the best program for our employees is, both from the covered standpoint and cost standpoint.

Q The underlying accident, which is the subject matter of this lawsuit, occurred in November, 1983.

Your company was called ISI at that time.

A The company was called Insurance Systems Incorporated, yes.

Q And Patricia Kanakis was an employee of the company at the time?

A To the best of my knowledge, yes.

Q By whom did your employees have health benefits with that company or with—for your company?

A At that time we were covered by Mutual of New York for our life—some of our life and our health insurance, in addition to which we were covered by Standard Insurance Company of Oregon for disability, life, accidental death and dismemberment.

I don't recall dental or eye carrier.

Q As far as the employees were concerned, would they be covered completely by your company?

A Yes, it is our policy, had been our policy at that time and continues to be our policy that the company picks up 100 percent of the cost of the employees' [324] policy started July 1st of 1983, to the best of my knowledge, is the effective date.

Q In November, 1983, about how many employees did Care have or Insurance systems incorporated have?

A Can you repeat that date?

Q November, 1983, July to November, 1983.

A When I—the only approximate answer I can give to that is really, when I came from Insureco to ISI, I was approximately the sixtieth employee to come.

Q When was that?

A July 1 of 1983.

I don't recall how many we had in November.

Q The policy that your company had with MONY, what was your company's responsibility, if any, in handling that policy?

Did you do anything at all or was it all—did the company's broker or somebody else?

A I believe our responsibility was to have applications filled out for each employee and where they had beneficiaries for life or other type policies, they named.

We had responsibility for informing the insurance company of the fact that we had an employee and the fact we had responsibility to be certain we paid the premium directly to the company and reconciled their statement, regularly.

[325] We had a responsibility to act as a conduit for employee questions or problems regarding the policies, where questions may come up regarding why something is or isn't covered or predeterminations on various surgeries, other cases.

There's probably others but those are the ones that come right to mind.

Q You had no fiduciary named that handled any possible conflicts in coverage or anything of that nature?

MR. PIERIK: Objection, lack of foundation.

THE COURT: If you know, you may answer.

THE WITNESS: To the best of my knowledge, as I was not the person that put these policies in force, they were actually negotiated between the broker, benefit plan coordinators and chief executive officer of the company, Lauren Parsons.

I don't know whether there was ever a fiduciary appointed.

Q Were there any of the time, July to November, 1983, of your company?

MR. PIERIK: Objection, lack of foundation.

THE COURT: If you know, you may answer.

THE WITNESS: I don't know.

* * * *

[330] Q Adding or subtracting a dependent, something of that nature; is that right?

A Yes.

Q If he had a claim, they would forward onto the broker or company.

A We would not see it. It would go off to the company.

Q If somebody wasn't getting paid by Mutual of New York, your company wouldn't handle it?

A To the extent it was not being paid by Mutual of New York, they would come to our personnel and voice a concern or complaint and the personnel department would then interface with our broker and then, from that point, the broker would handle all of the leg work in determining the resolution to that problem.

Your company would pass it on to someone else, either directly or directly to the company, would not go directly to Mutual Life; is that it?

A Please rephrase that.

Q Your company, for the most part, interfaced directly with Mutual Life, would they?

A No.

Q Is that correct?

A That is correct.

* * * *

[335] Q Were they formerly known as Insurance Systems Incorporated?

A On June 30 of this year, Insurance Systems merged into Care Systems Corporation.

Q When did you first start working for Insurance Systems Incorpcrated [sic]?

A To the best of my knowledge, July 1st, 1983.

Q When you say "to the best of your knowledge" you are reasonably certain that was the day you started?

A Yes.

Q And what was the title that you held when you started with ISI in July, 1983?

A I was Vice-President and Chief Financial Officer.

Q By the time you started working with ISI, the Mutual policy, G21047, that has been referred to here, had already been negotiated; is that right?

A Yes.

Q That was by the Chief Executive Officer, Mr. Parsons, and the benefit plan coordinators with Mutual?

A Yes.

* * * *

[339] A Yes, they do.

Q Now, with reference to Exhibit E, to your deposition, I want you to compare that with what has been marked in this trial as Exhibit C and Exhibit 25 and see if Exhibit E, to your deposition, is, in fact, the same document as Exhibit 25 and—

THE COURT: "E" as in Edward.

MR. PIERIK: "E" as in Edward, to the deposition, is the same as Exhibit 25 that has been marked and the same as Exhibit C, which has been marked. These three are—do they appear to be the same?

A They appear to be the same, yes.

Q BY MR. PIERIK: My question to you, Mr. Ohrnstein, is whether Exhibit 25 which is the same as Exhibit

C, which is the same as Exhibit E to your deposition was distributed to the employees of ISI when ISI began coverage with Mutual of New York for group medical insurance.

A As I believe that, and prior to this document, Number 26, I believe they were distributed to employees but what I don't have is a system where employees signed off on something, sent me a bounce-back saying they, in fact, did receive it; therefore, my answer on the deposition and this testimony are inconsistent.

What can I tell you that would substantiate whether an employee received it.

[340] Q Whether, to the best of your knowledge, they did receive it, according to the custom and practice you were following at the time.

A If your question is regarding custom and practice, both documents, would be our custom and practice to distribute to employees.

They were specifically done for that purpose.

Not, again not by us, either by benefit plan coordinators or MONY. I don't know, whether it was, save it would be our custom and practice.

Q To distribute those?

A Yes.

Q To the best of your knowledge, Exhibit 25—I think we are referring to there—was distributed to your employees?

A Following the same response to 25.

Q Now, with respect to Exhibit, I believe this one has been marked—what was marked as Exhibit F to your deposition, which is a letter from Mutual of New York to Mr. Ohrnstein, dated July 22, 1983.

Do you have—did you have, that letter in your files, Mr. Ohrnstein, at ISI?

A Yes, I did.

MR. PIERIK: I will be marking this—I don't believe it has been marked, has it, Miss Clerk?

THE COURT: We don't have an "F."

COURT'S SPECIAL INSTRUCTION NO. 2

For there to be an ERISA employer benefit plan, these five elements must exist:

1. A plan, fund or program;
2. established or maintained;
3. by Insurance System Inc. (ISI), the employer of plaintiff Patricia Kanakis, wife of plaintiff Telly Kanakis;
4. for the purpose of providing medical, surgical, hospital care, sickness, accident, disability benefits;
5. for ISA's participants or their beneficiaries.

(*Donovan v. Dillingham* 688 F.2d 1367, 1371.)

COURT'S SPECIAL INSTRUCTION NO. 4

The second of the elements listed above to prove that an ERISA employee benefit plan exists—(the plan, fund or program is) *established or maintained*—is proved if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits, and if ISI intended to establish an ERISA plan, being aware that the plan existed. (*Wayne Chemical Inc. v. Columbus Agency Serv.* 567 F.2 692, 699); *Donovan v. Dillingham* 688 F.2d 1367, 1373.)

July 31, 1983

TO OUR EMPLOYEES

It gives us considerable pleasure to announce to you that we have completed arrangements for a plan of Group Insurance offering benefits for you and your dependents.

Our Plan is known as the Insurance Systems, Incorporated Employee Benefit Plan and is being underwritten under a group insurance contract issued by Mutual Of New York, one of the oldest and strongest insurance companies in America.

This announcement and the accompanying booklet are designed to meet the Summary Plan Description requirements of the Employee Retirement Income Security Act of 1974 (commonly known as ERISA). For such purposes, the type of administration is Insurer Administration. We suggest that you read this material carefully so you will have a full understanding of the life insurance, and medical care coverages provided.

Special replacement provisions may apply if you were insured under our prior plan. If you should have any questions about this or about the Plan and its operation, you may consult with the Plan Administrator: Judi Wittick, Executive Administrator, 18900 Teller Avenue, Irvine, CA 92715.

The Agent for Service of Legal Process under the Plan is Insurance Systems, Inc. and such process may be served at 18900 Teller Avenue, Irvine, CA 92715.

You will be pleased to know that we will pay the entire cost of your insurance and a portion of the cost of your dependents' insurance. Your only cost will be the balance required for your dependents' insurance, if you elect such coverage.

We sincerely believe that the benefit offered are liberal and should be of great value to you and your dependents.

Insurance Systems, Inc.
18900 Teller Avenue
Irvine, CA 92715

Employer Identification
Number: 95-3048407

Statement of ERISA Rights

(Required by Federal Law and Regulation)

As a Plan participant you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be enitled to:

> Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
>
> Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
>
> Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

GROUP
INSURANCE
BENEFITS

Effective December 31, 1984

Insurance Systems, Incorporated

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SCHEDULE OF INSURANCE AMOUNTS

(For description of coverage see following pages)

INSURANCE FOR YOU

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Classification	Life Insurance *	Accidental Death and Dismemberment *
All Employees	Your effective Annual Earnings,** rounded to the next higher $1,000, but not more than $140,000.	

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* The amounts shown apply before the plan anniversary coincident with or next following your 70th birthday; after that 50% of the schedule amount applies.

** However, for those employees who are employed as salespersons, effective Annual Earnings shall include commissions for the preceding year.

FOR YOU AND YOUR DEPENDENTS

MAJOR MEDICAL BENEFITS

Lifetime Maximum		$1,000,000
*Cash Deductible—Each Calendar Year	$	100
Accumulation Period—12 months		
Family Maximum—Maximum deductible for all insured family members	$	300

For Each Calendar Year—Plan Pays—80% of the first $5,000 of covered expenses above the Cash Deductible and 100% of any balance—subject to the Lifetime Maximum.

Hospital Room and Board Maximum—the hospital's standard daily semi-private rate.

Mental and Nervous—Out Patient Maximum—50% benefit percentage; physician's charges limited to $20 and 50 days.

Home Health Care Supplement—Maximum 100 visits

*Not applicable to Home Health Care Visits.

OTHER MEDICAL CARE BENEFITS

Supplemental Accident—Per Accident Maximum $ 500

Convalescent Nursing Home—
Room and Board Maximum

For first 20 days —100% of the home's standard daily semi-private rate

For next 100 days—80% of the home's standard daily semi-private rate

Dependent Child Learning Impairment—
Lifetime Maximum $6,000

Benefit Percentage—80% of the first $200 of expenses for diagnostic testing; 50% of other covered expenses.

Prescription Drugs—Cash Deductible for
each prescription $ 1

Benefits shall also be payable for charges incurred in connection with pregnancy on the same basis as any other illness.

Not more than $10,000 will be payable for all medical care expenses incurred in connection with all mental and nervous conditions during any 12-consecutive month period.

ELIGIBILITY REQUIREMENTS

Plan Date

The effective date of the Plan is July 31, 1983. (Plan years end on the next following December 30th and on the same day of each calendar year thereafter.) The Plan was revised on December 31, 1984.

Employee Eligibility

You may become eligible under the Plan only if you are a full-time employee.

You become eligible on the first of the month coincident with or next following your date of employment.

Your coverage will become effective on the day you become eligible provided you are actively at work on that day if you do not complete one day of active full-time work on the day you would otherwise become covered, your coverage will be deferred until the day after you have completed one day of such work.

Dependents Eligibility

The following individuals are considered eligible dependents for the purposes of the Plan unless they are eligible for coverage as employees:

> Your wife or husband.
>
> Your unmarried children who have not reached their 23rd birthday. To continue to be eligible after his or her 19th birthday a child must be a full-time student at an accredited school or college and dependent upon you for more than 60% of his or her support.

A dependent's coverage will become effective on the latest of the day your coverage becomes effective, the day the dependent becomes eligible and the day you elect dependents coverage.

However, if you delay electing dependents coverage for more than 31 days after you first have an eligible dependent, each dependent then eligible will not become insured until the Insurance Company is furnished satisfactory proof of his good health.

CONTINUANCE OF DEPENDENT INSURANCE FOR HANDICAPPED CHILDREN

Our Plan contains a provision which provides that if an insured unmarried dependent child is mentally or physically incapable of earning his own living on the date he attains the limiting age specified under the Plan and he continues so incapacitated, his medical care coverage will continue beyond the limiting age provided the required proofs of such incapacity and its continuance are furnished the Insurance Company at regular intervals.

LIFE INSURANCE

FOR EMPLOYEES

The life insurance is payable in event of your death from any cause anywhere while you are insured.

You designate the person to receive payment, and you may change this beneficiary at any time by written notice to the Insurance Company through us.

When you terminate employment, your life insurance remains in force for 31 days. During this 31 day period you may obtain an individual policy of the same amount by applying to the Insurance Company for one of its permanent plans—without taking a medical examination.

Should you become totally disabled while insured and before your 60th birthday, and continue so disabled until death, your life insurance will be payable—even if you die after the 31 day period—provided you have submitted to the Insurance Company the required proofs of disability and its continuance each year. Similarly, should you become totally disabled after your 60th birthday but before your 65th birthday, your life insurance will be payable in event of your death within one year after you terminate employment.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

FOR EMPLOYEES

A benefit is payable in event of the loss of your life, limb or sight as a direct result of an accidental bodily injury sustained while you are insured, provided the loss occurs within 90 days of the accident—including losses resulting from occupational accidents.

The full amount for which you are insured will be paid for the loss of:

Life
Both Hands or Both Feet or Sight of Both Eyes
One Hand and One Foot
One Hand or Foot and Sight of One Eye

One-half the amount will be paid for the loss of one eye, one hand, or one foot.

Loss of a hand or foot means actual severance at or above the wrist or ankle joint, and loss of sight means its total and irrecoverable loss.

A benefit is payable to each covered loss, but the total payments for any one accident may not exceed the full amount for which you are insured.

Losses resulting from suicide, self-inflicted injury, war, certain aviation activities, and those attributable wholly or partly to disease are not covered under this benefit.

CONVALESCENT NURSING HOME BENEFIT

FOR EMPLOYEES AND DEPENDENTS

You will be paid for actual convalescent nursing home charges for room and board—to the daily amount for which you are insured—for each day of confinement as a bed patient in a nursing home, as the result of a non-occupational accident or a sickness for which benefits are not payable under any workmen's compensation law. The confinement must begin within 14 days after a covered hospital stay of at least 3 days and it must be recommended by a physician as necessary and related to the cause of the hospital confinement. This daily benefit is payable for a maximum period of 120 days for each confinement.

Successive nursing home confinements are considered as one unless separated by at least 60 days.

"Convalescent Nursing Home" means an institution for skilled nursing care (other than federal or state) with 24 hour medical supervision, available physician services, and individual daily medical records: it does not include any institution, or part thereof, used principally as a facility for rest, custodial care, drug addicts, alcoholics, the aged, or remedial education, or training.

SUPPLEMENTAL ACCIDENT BENEFIT

FOR EMPLOYEES AND DEPENDENTS

If, as a direct result of/and during the 90 days following a non-occupational accidental bodily injury, medical care expenses are incurred which exceed any benefits payable under the Prescription Drug Benefit, you will be paid for the excess expenses—up to the Supplemental Accident amount for which you are insured.

Hospital confinement is not required, but the injury must be sustained while insured and the medical care must be recommended by a legally qualified physician.

Medical care expenses are reasonable charges for physicians and nurses services, hospital treatment, and x-ray and laboratory examinations. Dental work or treatment is covered only if resulting from injury to sound, natural teeth.

PRESCRIPTION DRUG EXPENSE BENEFIT

FOR EMPLOYEES AND DEPENDENTS

You will be paid a benefit for actual charges incurred while insured, for covered prescription drugs which are prescribed by a legally qualified physician as necessary for treatment of a sickness or injury and dispensed by a licensed pharmacy.

Covered Prescription Drugs

Covered Prescription Drugs are:

(a) Federal Legend Drugs—those bearing a label which states "Caution: Federal Law prohibits dispensing without prescription."

(b) State Restricted Drugs—those which may not require a prescription under Federal law but do require a prescription under State Law.

(c) Compounded Medications which contain a Federal Legend or State Restricted Drug.

(d) Insulin, by written prescription only.

The plan will pay the cost of these drugs in excess of the Deductible.

Drugs are covered in the quantity your physician prescribes, up to a 34 day supply, or 100 unit doses, whichever is greater.

Deductible

The Deductible is $1. You must pay this amount for each prescription and each refill; the plan pays the rest.

Charges Not Covered

Of course, charges which the individual is not legally obligated to pay or those in excess of what is customary and reasonable are not covered. Nor are benefits payable for expenses in connection with charges for:

1. Occupational injury or sickness or for which the individual is entitled to benefits under any workmen's compensation law.
2. Contraceptives and therapeutic devices or appliances, regardless of intended use, and immunizing agents, biological sera, blood or blood plasma and injectible substances other than injectible insulin.
3. Non-legend drugs or the administration of any drug.
4. Any prescription refill in excess of the number prescribed by the physician, or any refill dispensed after one year from the date of the physician's original prescription.
5. Medication taken by or administered to the individual while a patient in a licensed hospital, extended care facility, nursing home or similar institution.
6. Drugs consumed or administered at the place where dispensed.
7. Drugs labelled "Caution—limited by federal law to investigational use" or experimental drugs.

MAJOR
MEDICAL
BENEFITS

FOR EMPLOYEES AND DEPENDENTS

You will be paid a benefit for medical expenses incurred as a result of a non-occupational accident or a sickness for which benefits are not payable under any workmen's compensation law, as outlined below.

The Benefit

When an insured individual has incurred enough eligible medical expenses within a calendar year to satisfy his Deductible, the plan pays 80% of the first $5,000, plus 100% of any balance, of the eligible medical expenses he subsequently incurs during that year, up to the maximum benefit.

> The deductible, eligible medical expenses and other provisions affecting payment of this benefit are explained on the following pages.

The Deductible

The Deductible amount each calendar year is $100.

It is not necessary to satisfy the Deductible for each illness or accident—it is applied only once each calendar year against an individual's eligible expenses for all illnesses and accidents during the year.

The Deductible requirement is liberalized in the following instances, although the Deductible amount must nevertheless be satisfied by expenses incurred within 12 consecutive months:

1. Eligible medical expenses incurred and applied toward the Deductible in the last 3 months of a year may be used in satisfying the Deductible for the next year.

2. When two or more insured members of a family are injured in the same accident, only one Deductible applies to all eligible expenses resulting from the accident in that and the next year.

3. If all insured members of a family incur, during the same year, eligible medical expenses to which the Deductible applies in an amount equal to $300, all insured members of that family are considered as having satisfied their Deductible so that benefits are payable with respect to eligible expenses subsequently incurred that year.

Maximum Benefit

The total benefit payable for any person during his lifetime will not exceed his Maximum amount as shown in the Schedule of Insurance Amounts. However, a person may reinstate his full Maximum—after he has received benefits totalling more than $1,000—by furnishing the Insurance Company with satisfactory evidence of his good health. In addition, up to $1,000 of the used portion of his Maximum will be automatically restored each January 1 regardless of his health.

Covered Medical Expenses

Medical expenses eligible for benefits include charges for the following medical care and services, except as stated below, incurred while insured on the authorization of a legally qualified physician and provided, in the geographical area where received, such care and service is customary and reasonable for the condition being treated:

1. Regular hospital room and board charges (including general or floor nursing care) up to the hospital's standard daily rate for a semi-private room.

2. All hospital charges while confined to an intensive care unit.

3. Other charges made by a hospital for medical care and treatment.

4. Charges made by a legally qualified physician for diagnosis, treatment and surgery.

5. Charges made by a graduate registered nurse or licensed physical therapist (other than a member of the immediate family) for nursing care or physical therapy.

6. Charges made for professional ambulance transportation to or from a local hospital, or for transportation within the United States and Canada by professional ambulance, railroad or regular commercial passenger aircraft flight to the nearest hospital equipped to furnish special treatment not available in a local hospital.

7. Charges for the following services and supplies:
    (a) X-ray examinations, and microscopic or laboratory tests;
    (b) Anesthesia, oxygen, and their administration;
    (c) X-ray or radioactive isotope therapy;
    (d) Blood, blood derivatives, and their administration;
    (e) Casts, splints, trusses, braces, crutches, surgical dressings, and artificial limbs or eyes;
    (f) Rental of iron lung or other mechanical equipment for treatment of respiratory paralysis, wheelchair, hospital-type bed, and equipment for the administration of oxygen.

Charges, as described above, in connection with any nervous or mental condition are eligible. However, in determining the benefit for any such charges incurred while the individual is not hospital confined as a bed patient, the benefit percentage will be 50% and eligible physician's charges for psychiatric services will be limited to no more than $20 (i.e., a maximum benefit of $10) for each day of visits, up to 50 days in any calendar year.

Medical Expenses Not Eligible

Of course, charges which the individual is not legally obligated to pay or those in excess of what is customary and reasonable for the geographical area for an otherwise eligible expense, or those reimbursed under the Supplemental Accident or Prescription Drug benefits are not eligible. Nor are benefits payable for expenses in connection with the following:

1. Occupational injury or sickness, or an injury or disease resulting from war.
2. Health or check-up examinations—unless necessary for treatment of a sickness or injury.
3. Care of a newborn child not yet discharged from the hospital—except for charges to treat premature birth, congenital injury or sickness, or sickness or injury sustained during or after birth.
4. Dental work or treatment, eye examinations, eyeglasses or contact lenses, hearing aids and comestic surgery—except for charges to treat an accidental injury sustained while insured, which are incurred within 24 months after the accident, if the treatment giving rise to them begins within 90 days after the accident. Dental work and treatment only covers injury to sound, natural teeth.
5. Treatment, therapy, remedial education or training program which is principally intended to overcome or compensate for any learning impairment. (See following pages for other benefits provided.)
6. Treatment of myopia and other errors of refraction: orthoptics or visual training; and the fitting or placing of eyeglasses or contact lenses.

7. Alcoholism or drug addiction (including narcotism)—except for charges incurred while a bed patient in a hospital.

"Hospital" means an institution (other than federal or state) with 24-hour nursing, diagnostic and major surgical facilities. It does not include any institution or part thereof, used principally as a facility for rest, nursing, convalescence, the aged, or remedial education or training.

Expenses in connection with a condition requiring medical care or treatment within 3 months before an individual becomes insured are subject to the following limitation: such expenses are not eligible unless they are incurred after the earliest of (a) a 3 month period ending while he is insured and during which he incurs no expenses in connection with that condition, (b) a 12 month period during which he is continuously insured, or (c) in the case of an employee, a 6 month period during which he is continuously insured and at active full-time work.

HOME HEALTH SERVICES SUPPLEMENT

FOR EMPLOYEES AND DEPENDENTS

Covered home health service charges are included as eligible expenses under our Major Medical Plan.

The Benefit

Covered charges during the year are reimbursed the same as other eligible medical expenses up to a maximum of 100 Home Health Care Visits in that year. Each visit by a member of a home health care team, or four hours of service by a home health aide, is considered one visit.

Covered Charges

Covered Home Health Service charges are customary and reasonable charges made by a Home Health Agency for the following treatments, services and supplies furnished in accordance with a Home Health Care Plan:

1. Part-time or intermittent services of a home health aide.
2. Part-time or intermittent nursing care by, or under the supervision of, a registered nurse.
3. Physical, occupational or speech therapy.
4. Laboratory services by, or on behalf of, a Home Health Agency and medical supplies and medicines dispensed by a drug store and prescribed in writing by a physician to treat the individual for a specific illness or injury but only to the extent benefits would still have been available under the other medical care benefits of the Plan had the individual been hospital-confined as a bed-patient or confined in a skilled nursing facility due to this benefit not being available.

Covered Charges do not include charges for services, supplies or treatment received from the insured individual, a member of his immediate family or a person who ordinarily resides with you.

Definitions

"Home Health Agency" means a hospital, public agency, or non-profit organization, primarily engaged in providing skilled nursing services, which has been licensed pursuant to the laws of the state in which it is located or federally certified as a home health agency for participation in Medicare.

"Home Health Care Plan" means a program which is specially intended to provide medical care and treatment of a condition that would otherwise require hospital confinement or confinement in a skilled nursing facility and which is established and approved in writing by a physician.

DEPENDENT CHILD LEARNING IMPAIRMENT BENEFIT

You will be paid a benefit for expenses incurred in a Remedial Clinic by your insured dependent child as a result of a learning impairment.

The Benefit

The plan pays 80% of the first $200 of charges made by a Remedial Clinic for administering an initial series of evaluation tests to diagnose the nature of the learning impairment and 50% of (i) room and board charges by a Remedial Clinic, (ii) charges for Educational Therapy and (iii) charges for the administration of standard achievement tests. However, not more than $1,500 of benefits shall be paid for all such charges incurred within a period of 6 consecutive months.

Maximum Amount

The maximum benefit payable during each insured dependent child's lifetime is $6,000.

Charges Not Covered

Of course, charges which the individual is not legally required to pay or are not incurred on the recommendation of a physician or are in excess of what is customary and reasonable are not covered. Also, benefits are not payable for charges in connection with the following:

(a) Tutoring in specific subjects.

(b) The purchase or rental of books, tools, equipment, implements, eyeglasses, contact lenses, hearing aids or supplies of any kind.

(c) Travel or participation in sports, hobbies, encampments and other activities which are principally recreational.

Definition of Remedial Clinic

"Remedial Clinic" means an institution (other than federal or state) used principally for remedial education or training through Educational Therapy and having 24 hour medical supervision, supervised therapeutic care and the services of a physician available at all times.

Treatment Plan

When treatment of a learning impairment is contemplated for an insured dependent child on the recommendation of a physician, a written treatment plan formulated by a Remedial Clinic should be submitted to MONY before treatment begins.

MEDICAL CARE COVERAGE FOR THOSE ELIGIBLE FOR MEDICARE

In order to comply with the requirements of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Plan has been modified so that any provision excluding or reducing medical care coverage because of eligibility for Medicare shall not apply to:

(a) active employees who are eligible for Medicare and are age 65 through 70; and

(b) spouses of employees described in (a) who also are eligible for Medicare and are age 65 through 70.

"Age 65 through 70" means the period from the first day of the month in which the person attains his or her 65th birthday until the last day of the month in which the person attains his or her 70th birthday.

However, if you are subject to this modification, you may elect to reject the Plan's medical care coverage for yourself, or for yourself and your dependent spouse. If you opt out of the Plan, the medical care coverage described in this booklet will not apply to you (and your spouse, if applicable). Please see the Plan Administrator for details regarding this election.

If you wish to change your election, the Insurance Company may require proof of good health before you (and your spouse, if applicable) can become insured.

This modification does not apply to individuals who have permanent kidney failure.

COORDINATION WITH OTHER COVERAGE

Our plan contains a provision which coordinates its benefits with similar benefits provided by other plans. Other plan means any (1) group or franchise insurance, employee benefit, Blue Cross, Blue Shield or other group plan arranged through an employer, trustee, union or association (2) program created by a national government agency thereof, or (3) where permitted by law, no fault insurance plan; which provides benefits for medical or dental care or treatment.

If a covered individual is also covered under another plan, such individual's total benefits under both plans for care, services or supplies should not exceed 100% of any necessary reasonable and customary expenses.

Payment of benefits will be resolved as follows:

1. If the other plan does not contain a Coordination of Benefits provision, the benefits of that plan will be determined before determining the benefits of this plan.
2. If the other plan does contain a Coordination of Benefits provision, the benefits of that plan will be coordinated with the benefits of this Plan. Payment will be made in the order listed, by the Plan under which the covered individual is entitled to receive benefits:

(a) other than as a dependent

(b) as a dependent of a male

(c) as a dependent of a female.

If priority cannot be established by the above, priority will be given to the Plan which has covered the claimant for the longer period of time.

3. In the case of a covered child of legally separated or divorced parents:

    (a) the Plan of the parent having custody will be primary over the Plan of the parent without custody.

    (b) if the parent with custody remarries, the Plan of the natural parent with custody will be primary over the Plan of the step-parent. The Plan of the step-parent will be primary over the Plan of the natural parent without custody.

MEDICAL EXPENSE CONVERSION PRIVILEGE

When you terminate employment after being insured for at least 3 months, you may obtain an individual premium-paying policy providing medical care coverage for yourself only or, if you had dependents coverage under the Plan, for yourself and your dependents. To obtain this policy you must apply to the Insurance Company and pay the first premium within 31 days after your insurance under the Plan terminates.

The type, amount, duration and terms of the benefits available will depend on the policy form being offered by the Insurance Company for conversion purposes at the time you apply.

No evidence of insurability is required for the individual policy, but the Insurance Company reserves the right not to cover any person whose other medical care coverage together with that under the individual policy would result in overinsurance or duplication of benefits under its standards.

If your dependents are insured under the Plan, this privilege is also available to (a) your surviving spouse, with respect to such of your dependents as are insured, at your death, (b) a dependent child, with respect to himself, upon attaining the limiting age for dependents eligibility and (c) an insured spouse, with respect to such spouse, upon divorce or annulment.

GENERAL PROVISIONS

Application for Insurance

All eligible employees will be asked to fill out a simple enrollment card. Please complete all questions carefully as this card will be used in preparing your certificate.

If you wish coverage for your dependents, you must also sign a payroll deduction authorization for your contributions.

No Medical Examination

No medical examination is required for your insurance unless you were previously insured under the Plan and had exercised any conversion privilege.

Policy and Certificate

This booklet is a brief summary of the principal features of the Plan and is not a contract. Operation of the Plan is governed by the terms of the contract issued by MONY.

When you become insured, you will receive an individual certificate outlining the details of your coverages.

Termination

Your insurance will terminate at the end of the month if you leave our employ, are no longer employed in an eligible class, or when this plan is discontinued.

Coverage for your dependents also will terminate if you withdraw your payroll deduction authorization.

Important

Please notify us at once when you acquire an additional eligible dependent—or when one of your dependents is no longer eligible.

CLAIMS PROCEDURE

Claim forms may be obtained by contacting the Plan administrator or his designee.

Procedures To Follow Upon Receipt Of The Form

Read the instructions carefully.

Also, be sure the provider of the service (the physician or the hospital, etc.) has completed the form. Return the completed claim form and accompanying material to MONY'S Regional Group Claim Office.

When Claim For Benefit Is Denied

If the Claim is denied either in whole or in part, the Claimant will receive written notification of such denial within a reasonable period of time after it has been submitted. Generally, you will be informed within a week or so if there is any such denial. However, Department of Labor Regulations require that you be informed that a period of time in excess of 90 days after the claim is received by the plan is generally excessive, unless special circumstances require an extension of up to an additional 90 days. Notification of claim action will include the reason for denying the claim, including specific reference to pertinent plan provisions. If additional requirements are necessary for a reconsideration of the denial, such requirements will be included in the written notice.

Appeal Upon Denial Of Claim

The Claimant may, within 60 days after the claim is denied, submit a written request to the Plan Administrator for reconsideration, including a request for review of pertinent documents, and including issues and comments. Such request should be accompanied by whatever documents or records may be available to support the appeal. The request will receive prompt attention and the Claimant will be advised of the decision, in writing, not later than 60 days or, if special circumstances exist, 120 days after the request for review is received.

SPECIAL PLAN PROVISIONS

To meet applicable statutory requirements, the plan description on the previous pages is modified as follows:

Any reference in the medical care benefits to dental work, dental diagnosis or dental treatment shall mean work, diagnosis or treatment which concerns the teeth or gums.

The benefits provided for services which are within the scope of a licensed certified social worker; speech pathologist; marriage, family and child counselor; occupational therapist or audiologist are payable whether performed by a Doctor of Medicine or one of the above to whom the insured individual was referred by a physician.

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No. 90-327

Supreme Court, U.S.
FILED
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JOSEPH F. SPANIOL, JR.
CLERK

In The

Supreme Court of the United States

October Term, 1990

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THE MUTUAL LIFE INSURANCE COMPANY
OF NEW YORK, NANCY A. HIORTDAHL
AND DON LUHRSEN,

Petitioners,

v.

TELLY KANAKIS AND PATRICIA KANAKIS,

Respondents.

◆

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF CALIFORNIA

◆

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◆

MISSTATEMENTS OF FACT AND LAW IN PETITIONERS' STATEMENT OF THE CASE

Pursuant to 15.1, Rules of the Supreme Court of the United States, Respondents Telly Kanakis and Patricia Kanakis hereby address the statements of fact in Petitioners' STATEMENT OF THE CASE.

I

THERE WAS NO "WINDFALL" TO SERIOUSLY INJURED RESPONDENT TELLY KANAKIS.

Petitioners state on page two of their petition that respondent Telly Kanakis withdrew his claim against

Benefit Fund and pursued his claim against Petitioner Mutual of New York because Respondent "was interested not in coverage, but a windfall." Petitioners "explain" in footnote one on page three that Respondent's $50,000 settlement from the third-party motorist involved in the accident causing the injuries to Respondent exceeded Respondent's total medical expenses and, if Respondent had not withdrawn his claim against Benefit Fund, he would have been required to reimburse Benefit Fund with the settlement he received.

This point was urged by Petitioners in the form of a double recovery argument before the California Court of Appeal which rejected it as "without merit in fact or law." (Appendix to Petition for Writ of Certiorari, p. 17a.) The Court of Appeal reasoned as follows:

> " . . . Telly's hospital and medical insurance expenses here amounted to some $36,897.69. Telly sustained fractures of his left leg – tibia, fibula, and femur – and had nerve damage to his left arm as well as dislocation of his jaw, left wrist and right finger. Five months after the accident he still had a severe paralysis of his left arm, he was in bed for five months after the accident and in a wheelchair for three months after that, unable to move without help of his wife. He had a rod in his leg from the accident at the time of trial. It was not removed within a year of the accident because of Telly's financial inability. He could not raise his left arm at time of trial. He has no income whatsoever from the time of the accident until September. To argue that there will be a double recovery is again without factual support. This settlement was made without allocation as to future medical expenses, pain and suffering, loss of wages, etc. After applying $36,000 of the $50,000 recovery

> to medical costs incurred, there remained less than $14,000 for loss of earnings, pain, suffering and the permanent disability sustained by Telly Kanakis. This argument for reversal is without merit in fact or law." (Appendix to Petition for Writ of Certiorari, pp. 16a-17a.)

II

THE EVIDENCE DOES NOT SUPPORT THE PETITIONERS' CONTENTION THAT RESPONDENT PATRICIA KANAKIS RECEIVED ANY INFORMATION THAT HER MEDICAL INSURANCE WAS AN ERISA PLAN; SUBSTANTIAL EVIDENCE SUPPORTS THE OPPOSITE CONCLUSION WHICH IS INHERENT IN THE JURY'S VERDICT.

On page four of the Petition, it is stated that, four months prior to the accident of Telly Kanakis, the employer of Respondent Patricia Kanakis distributed to her an announcement that it had arranged for a medical coverage plan which was "designed to meet [ERISA] requirements and which was accompanied by a 'statement of ERISA rights.' "

In absolute contradiction to these statements, the California Court of Appeal in its opinion stated that Respondent Patricia Kanakis "was not told the insurance policy from MONY was under ERISA rules. The book she received from her employer did not mention the word ERISA. The subject had never been discussed with her." (Appendix to Petition for Writ of Certiorari, p. 5a.)

In support of their argument, Petitioners rely on selected testimony from Matthew Ohrnstein which is attached to the Petition for Writ of Certiorari at pp. 39a-43a.

Other relevant portions of the transcript including testimony of Ohrnstein and respondent Patricia Kanakis are set forth in the appendix. Ohrnstein, the executive vice president and chief financial officer of respondent Patricia Kanakis' employer was a certified public accountant who had graduated from Penn State University and had been employed as such in New York City and Los Angeles. (p. 1A) He testified that his "responsibility is in the acquisition of insurance policies for employees and for the company as a whole" and that he dealt "with an insurance broker who actually handles the one-on-one negotiating with the companies," and that he "rarely if ever [had] communications with the company, the insurance company." (pp. 2A-3A) He was the one in charge of handling the insurance needs of the company and knew very little about ERISA. (p. 4A) Prior to his deposition he does not recall ever seeing Exhibit No. 24 which is entitled "Mutual of New York, Summary of Certain Provisions of Employee Retirement Income Security Act." (p. 5A) Ohrnstein did not know if there were fiduciaries for the insurance, he knew that the company paid the premiums, changed names and addresses, added or subtracted dependents and forwarded claims to the broker or the insurance company and if the claim was not being paid, the company would interface with the broker who would then handle the leg work in resolving the problem. (p. 6A) Ohrnstein did not know if his company had an ERISA policy in 1983 (pp. 7A-8A). The July 31, 1983 letter, Exhibit No. 25, was not drafted by Ohrnstein's company and he could not say whether it was given or distributed to Respondent Patricia Kanakis. (p. 9A) Reviewing the

July 31, 1983 letter did not refresh Ohrnstein's recollection as to whether or not his company had an ERISA plan. (pp. 9A-10A)

Respondent Patricia Kanakis received a booklet from her employer and there was nothing within that booklet mentioning ERISA and she had never heard of that term before. That term was never discussed with her. (pp. 11A-12A)

Under *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58 (1987) ERISA preemption is a federal defense and the burden is on the party raising this defense to prove the facts necessary to establish it. Petitioners' contention on page four that Respondent PATRICIA KANAKIS received a July 31, 1983 letter referring to an ERISA plan was rebutted by her denial that she had ever received anything referring to ERISA and that anyone had ever mentioned ERISA to her and by Matthew Ohrnstein's statement that he could not say she had ever received the letter. The issue over the existence of an ERISA plan was submitted to the jury which found that there was no ERISA plan. That jury verdict was upheld by the trial judge who entered judgment in the case. The California Court of Appeal unanimously sustained the trial judge and the California Supreme Court unanimously refused to grant review of the Court of Appeal decision.

III

PETITIONERS HAVE OMITTED SIX OUT OF THE EIGHT ERISA INSTRUCTIONS GIVEN TO THE JURY.

Petitioners provide a misleading impression of the jury instructions on what constitutes an ERISA plan. They refer to Special Instruction No. 2 which is Jury Instruction No. 27 setting forth the five elements of an ERISA plan as set forth in *Donovan v. Dillingham,* 688 F.2d 1367 (11th Cir. 1982). They state that "the Trial Court then instructed the jury" with Special Instruction No. 4, which is Jury Instruction No. 31 and which is set forth in the Petition. In addition to these two jury instructions, the court also gave jury instructions 26, 28, 29, 30, 32 and 33, all of which dealt with what constitutes an ERISA plan. All of the ERISA plan instructions given by the trial court and as set forth in the clerk's transcript are as follows:

No. 26

> The defendants have the burden of proving by a preponderance of the evidence all of the facts necessary to establish:
>
> I. An ERISA employee benefit plan has been established or maintained by ISI.
>
> . . .
>
> "Preponderance of the evidence" means evidence that has more convincing force than that opposed to it. If the evidence is so evenly balanced that you are unable to say that the evidence on either side of an issue preponderates, your finding on that issue must be against the party who had the burden of proving it.
>
> You should consider all of the evidence bearing upon every issue regardless of who produced it. (Clerk's Transcript (hereinafter C.T.) 390.)

No. 27

> For there to be an ERISA employer benefit plan, these five elements must exist:

1. A plan, fund or program;
2. established or maintained;
3. by Insurance Systems Inc. (ISI), the employer of plaintiff Patricia Kanakis, wife of plaintiff Telly Kanakis;
4. for the purpose of providing medical, surgical, hospital care, sickness, accident, disability benefits;
5. ior ISA's participants or their beneficiaries.

(*Donovan v. Dillingham*, 688 F.2d 1367, 1371.) (C.T. 391.)

No. 28

The term "participant" of an employee benefit plan includes an employee of an employer who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or whose beneficiaries may be eligible to receive any such benefit. The term "employee" means any individual employed by an employer. (C.T. 392.)

No. 29

The term "beneficiary" of an employee benefit plan means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder. (C.T. 393.)

No. 30

For the first of the above elements – (a plan, fund or program) – to be proved, there must exist the following:

1. intended benefits;
2. intended beneficiaries;
3. a source of financing;
4. a procedure to apply for and collect benefits.

(*Donovan v. Dillingham*, 688 F.2d 1367, 1372.) (C.T. 394.)

No. 31

The second of the elements listed above to prove that an ERISA employee benefit plan exists – (the plan, fund or program is) *established or maintained* – is proved if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits, and if ISI intended to establish an ERISA plan, being aware that the plan existed. (*Wayne Chemical Inc. v. Columbus Agency Ser.* 567 F.2d 692, 699); *Donovan v. Dillingham* 688 F.2d 1367, 1373.) (C.T. 395.)

No. 32

The purchase of a group policy of insurance covering a class of employees offers substantial but not conclusive evidence that a plan has been established. (C.T. 396.)

No. 33

An employee benefit plan is not required to be established by a formal written plan. If an employer has an employee benefit plan, there are certain fiduciary and reporting requirements, but these requirements are the responsibilities of the administrators and fiduciaries of plans covered by ERISA and are not prerequisites to coverage under ERISA. (C.T. 396.)

As a totality the jury instructions given by the trial court were fair and did not constitute error.

IV

THE UNPUBLISHED COURT OF APPEAL OPINION CANNOT CONFLICT WITH ANY PUBLISHED UNITED STATES SUPREME COURT OR FEDERAL COURT OF APPEAL DECISION AND PRESENTS NO ISSUE OF PUBLIC IMPORTANCE.

Petitioners point out that the California Court of Appeal decision was not published but they fail to note the significance under California Rules of Court. The Court of Appeal opinion states on its face in this case, "NOT TO BE PUBLISHED."

California Rules of Court prohibit the publication of a Court of Appeal opinion unless a majority of the court (976(c), Rules of Court) certify that the opinion meets one or more of the following standards set forth in Rule 976(b), California Rules of Court:

> "(1) establishes a new rule of law, applies an existing rule to a set of facts significantly different from those stated in published opinions, or modifies, or criticizes with reasons given, an existing rule;
>
> (2) resolves or creates an apparent conflict in the law;
>
> (3) involves a legal issue of continuing public interest; or
>
> (4) makes a significant contribution to legal literature by reviewing either the development of the common law rule or the legislative or judicial history of a provision of a constitution, statute, or other written law."

Rule 977, California Rules of Court provides that an unpublished opinion "shall not be cited or relied on by a court or a party in any other action or proceeding except . . . when the opinion is relevant under the doctrines of law of the case, res judicata, or collateral estoppel" or when the opinion states relevant reasons for a decision affecting the same defendant or respondent in another criminal or disciplinary action or proceeding.

The labeling of the Court of Appeal opinion as not for publication means that the three justice Court of Appeal and the California Supreme Court decided that the Court of Appeal opinion does not establish a new rule of law, that it does not resolve or create an apparent conflict in the law, that it does not resolve a legal issue of continuing public interest, and that it does not make a significant contribution to legal literature.

The unpublished opinion cannot be said to be in conflict with any reported decision of the United States Supreme Court or Federal Court of Appeals because the unpublished opinion cannot be cited or relied upon and therefore has no "existence" other than under the doctrines of the law of the case, res judicata, etc. There are no constitutional rights of any of the parties impacted by the Court of Appeal decision. It is respectfully submitted that no public importance exists in the instant case and the Petition for Writ of Certiorari should be denied.

PETITIONERS' REASONS FOR GRANTING THE WRIT ARE WITHOUT MERIT

I

PETITIONERS MISSTATE THE LAW OF THE ELEMENT OF INTENT IN THEIR DISCUSSION OF *SHAW V. DELTA AIRLINES* AND DECISIONS BY THE FEDERAL COURTS OF APPEAL.

In Section I under Reasons for Granting the Writ, petitioners attack the California Court of Appeal's statement that, "as a prerequisite to the creation and existence of an ERISA plan, the employer must intend to create and to participate in such a plan." (Petition for Writ of Certiorari, p. 6.) Petitioners further argue that an "intent" requirement is contrary to *Donovan v. Dillingham, supra,* 688 F.2d 1367 and to "numerous circuit courts that have adopted" the rule and further "contravenes" reasoning in *Shaw v. Delta Airlines,* 463 U.S. 85 (1983).

Petitioners make no reference to the California Court of Appeal's statement that, "case authority supports such an instruction," (Petition for Writ of Certiorari, p. 14a) or to the California Court of Appeal's direct quotation from *Wayne Chemical, Inc. v. Columbus Agcy. Serv. Corp.,* 567 F.2d 692 (7th Cir. 1977) which requires intent and reads as follows:

> "An employer does not become a participant in, or establish or maintain, a plan by applying for insurance and paying premiums for what it understands to be insurance without any knowledge that the plan exists. *Establishing, maintaining, or participating in a plan requires an intent,* . . . " (Appendix to Pet. for Writ, pp. 14a-14b.)

Petitioners' only reference to the *Wayne Chemical* case is in footnote 3 on page 7 of the Petition for Writ of Certiorari where they discuss not the California Court of Appeal's analysis of the *Wayne Chemical* case but the trial court's reliance on *Wayne Chemical* and Petitioners argue that, "*Wayne Chemical,* however, states merely that establishing a plan 'requires an intent which presupposes an awareness of the existence of the plan.' . . . that language does not support an instruction that specific intent is required to establish an ERISA plan." Petitioners then declare in the same footnote that "even the court that decided *Wayne Chemical* [the 7th Circuit] has embraced the *Dillingham* criteria" citing *Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.,* 805 F.2d 732 (7th Cir. 1986). But the very case cited by Petitioners in fact states as follows,

> "Thus, although *Donovan* and *Taggart* are not controlling here, they do support the defendants' broader contention that we should examine the corporation's intent." (*Id.* at p. 738.)

Petitioners further argue on p. 7 of their Petition that the "*Dillingham* standard" has been adopted by the Second, Fifth, Seventh, Eighth, Ninth and Eleventh Circuits in determining the existence of an ERISA plan, implying in their argument that this rejects any consideration of the employer's intent. However, in support of their argument petitioners cite incredible authority. In their footnote on page 7, they cite a district court case from the Western District of New York as establishing the rule for the entire Second Circuit, a district court case from the Southern District of Mississippi as establishing the rule for the entire Fifth Circuit and a district court case for the Northern District of Alabama as establishing the rule for the entire Eleventh Circuit. Their authority for the Seventh Circuit, the *Ed Miniat* case, was discussed in the previous paragraph and supports the requirement of intent. The Eighth Circuit decision cited by petitioners, *Harris v. Arkansas Book Co.*, 794 F.2d 358, 360 (8th Cir. 1986) found no ERISA plan in that case.

More incredibly, Petitioners' statement on page seven of their Petition that the Ninth Circuit has adopted "the *Dillingham* standard" which they state on page six of their Petition as contrary to an intent requirement, totally ignores the 1988 Ninth Circuit decision in *Kanne v. Connecticut Gen. Life Ins. Co.*, 859 F.2d 86, 99 (9th Cir. 1988), amended on denial of rehearing, 867 F.2d 489 (1988) (en banc), cert. denied, 109 S.Ct. 3216 (1989). The California Court of Appeal commented on the *Kanne* case as follows:

> " . . . In *Kanne v. Connecticut Gen., supra,* 859 F.2d 96, the federal court pointed out that, *'the plan brochure submitted by Connecticut General as an exhibit at trial describes the plan as an ERISA plan, evidencing the intent of ABC to create an ERISA plan.'* (*Id.* at p. 99, emphasis added.)
>
> We hold that as a prerequisite to the creation and the existence of an ERISA plan, the employer must intend to create and to participate in such a plan. Such intent may be found in acts as well as words. (*Kanne v. Connecticut Gen., supra,* 859 F.2d at p. 99.)" (Appendix to Pet. for Writ, p. 15a.)

It is clear that the California Court of Appeal's reliance on intent as a factor is based on the Ninth Circuit *Kanne* decision. California is within the Ninth Circuit geographical area.

Petitioners' analysis of *Shaw v. Delta Airlines, Inc.*, *supra*, 463 U.S. 85, is misleading. That case involved whether an airline's multibenefit plan which provided benefits in addition to those required under a state disability benefits law came within an ERISA exemption. As pointed out in the *Shaw* opinion, at 463 U.S. 106, ERISA "Section 4(b)(3) exempts 'any employee benefit plan- . . . maintained solely for the purpose of complying with applicable . . . disability insurance laws.' "

Shaw reasoned that, "Section 4(b)(3)'s use of the word 'solely' demonstrates that the purpose of the entire plan must be to comply with an applicable disability insurance law." (*Id.*, at 206.) Thus, *Shaw* concluded, "the test is not one of the employer's motive – any employer could claim that it provided disability benefits altruistically, to attract good employees, or to increase employee productivity, as well as to obey state law – but whether the plan, as an administrative unit, provides only those benefits required by the applicable state law." (*Id.* at p. 106.)

Petitioners have misstated authority on the role of the employer's intent in the Second, Fifth, Seventh, Eighth, Ninth and Eleventh Circuits and have misconstrued the *Shaw* case. Their primary argument for granting a writ in this case should be rejected.

II

THE PETITIONERS' ATTEMPT TO DISTINGUISH THE *FORT HALIFAX* CASE IS WITHOUT MERIT AND THEY HAVE IGNORED THE NINTH CIRCUIT *KANNE* ANALYSIS OF THE REQUIREMENT OF THE EMPLOYER'S INVOLVEMENT IN THE ADMINISTRATION OF THE BENEFIT PROGRAM.

The California Court of Appeal opinion concluded that, "The focus of ERISA is on the administrative integrity of *employers'* benefit plans," that "ERISA preemption presumes some specie of administrative activities by the employer is taking place [citation omitted]" and that, "the existence or lack of existence of an ERISA plan depends upon the extent to which the employer is involved in the administration of the benefit program so as to implicate the concerns which gave rise to ERISA." (Petition for Writ of Certiorari, pp. 11a-11b.) In reaching that conclusion, the Court of Appeal pointed out that the United States Supreme Court in *Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1 (1987) observed that,

> " 'An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements.' " (Appendix to Pet. for Writ, p. 10a.)

The California Court of Appeal also quoted as follows from the *Fort Halifax* case:

> *" . . . the Maine statute not only fails to implicate the concerns of ERISA's pre-emption provision, it fails to implicate the regulatory concerns of ERISA*

> *itself.* The Congressional declaration of policy, codified at 29 U.S.C., 1001, states that ERISA was enacted because Congress found it desirable that 'disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of [employee benefit] plans.' . . . *The focus of the statute thus is on the administrative integrity of benefit plans – which presumes that some type of administrative activity is taking place.*" (*Id.*, p. 15, emphasis added.)
>
> The Supreme Court further declared, 'The foregoing makes clear both why ERISA is concerned with regulating benefit "plans," and why the Maine statute does not establish one. Only "plans" involve administrative activity potentially subject to employer abuse. The obligation imposed by Maine generates no such activity. There is no occasion to determine whether a "plan" is "operated" in the interest of its beneficiaries, *because nothing is "operated."* No financial transactions take place that would be listed in an annual report, and no further information regarding the terms of the severance pay obligation is needed because the statute itself makes these terms clear. It would make no sense for pre-emption to clear the way for exclusive federal regulation, for there would be nothing to regulate. *Under such circumstances, pre-emption would in no way serve the overall purpose of ERISA.*' (*Id.* at p. 16, emphasis added.) (Appendix to Pet. for Writ, p. 11a)

California is within the Ninth Circuit geographical area and the California Court of Appeal carefully analyzed the Ninth Circuit *Kanne* case as follows:

> "What is an employer plan under ERISA is illustrated in *Kanne v. Connecticut General Life Ins., Co., supra*, 859 Fed.2d 96, and cited by the California Supreme Court as an authoritative

> statement of the federal ERISA law in *Commercial Life Ins. Co. v. Superior Court, supra,* 47 Cal.3d 473, 482, 483. The plan brochure, introduced by the insurance company, described the plan as an ERISA plan. Associated Builders and Contractors (ABC) was an employer group to which the employer (Harlo Carpets) belonged, and was described as the administrator of the plan. The employer subscribed to a group health insurance plan administered by ABC. Pursuant to the requirements of ERISA, the plan was established as a trust entity, called the ABC Trust. It purchased a policy of group health insurance from Connecticut General. Kanne was an employee of Harlo Carpets and covered by the insurance policy. The *Kanne* court observed the Connecticut General brochure describes the plan as an ERISA plan, *"evidencing the intent of ABC to create an ERISA plan."* (*Kanne v. Connecticut General Life Ins. Co., supra,* 859 F.2d 96, 99, emphasis added.)
>
> It concluded ABC, the employers' group, was an administrator of the plan subject to ERISA regulations. The court also pointed out '[a] bare purchase of insurance, without any of the above elements present, does not constitute an ERISA plan (although it may be evidence of the existence of an ERISA plan).' (*Kanne v. Connecticut General Life Ins. Co., supra,* 859 F.2d 96, 99, emphasis added; see also *Donovan v. Dillingham, supra,* 688 F.2d 1367, 1375; *Martori Bros. Distributors v. James-Massengale* (9th Cir. 1986) 781 F.2d 1349, 1358.)" (Appendix to Pet. for Writ, p. 12a.)

The California Court of Appeal then applied the *Kanne* rules to the instant case:

> "Contrast the undisputed facts here. The only responsibilities and duties of the employer of Patricia Kanakis was to have the MONY

> applications filled out for each employee, to name the beneficiaries on the life insurance, to inform the insurance company who the employees were, to pay the premiums directly to the company, to reconcile the statements regularly, and to act as a conduit for employee questions or problems regarding the policies.
>
> There is a total lack of evidence here as to the nature of the employer's administrative participation in any plan. Patricia's employer simply obtained the medical benefits for its employees through the purchase of the MONY policy. It distributed the booklets to its employees describing the benefits and claims procedures." (Appendix to Pet. for Writ, pp. 12a-13a.)

From the foregoing, it is also clear that Congressional intent as discussed above is the answer to Petitioners' arguments on tax implications and public policy. As pointed out by the California Court of Appeal in its opinion, the *Fort Halifax* case stated that, " ' "[T]he purpose of Congress is the ultimate touchstone." ' " (Appendix to Pet. for Writ, p. 10a.)

Finally, in Petitioners' concluding paragraph on page 13, they put themselves in the guise of protectors for the employee as well as the employer by asserting the ERISA purpose of protecting the "millions of employees and their dependents" and the "public policy" argument that the California Court of Appeal decision "runs contrary to the ultimate interests of participants, employers and third parties administering plans." Their posturing is hypocrisy. Telly Kanakis was severely injured on November 29, 1983. He was covered by medical insurance for which his wife, Respondent Patricia Kanakis was paying on a monthly basis. The Petitioner insurer never paid a cent for the medical bills of petitioner Telly Kanakis until after the Application for a Stay of Enforcement of the Judgment was denied by Justice Sandra Day O'Connor in this case on June 18, 1990.

◆

CONCLUSION

For all of the foregoing reasons, the Writ of Certiorari should not issue.

Respectfully submitted,

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September 20, 1990

APPENDIX

EXCERPTS OF TRIAL TRANSCRIPT

TESTIMONY OF MATTHEW OHRNSTEIN

A Yes, I was a graduate of Penn State University, University Park, Pennsylvania, I have a Bachelor of Science Degree in Accounting. I am a certified public accountant, member of Pennsylvania Institute of CPA's and American Institute of CPA's.

Q Are you presently employed?

A Yes, I am.

Q By whom are you employed?

A Currently employed by Care Systems Corporation.

Q Is Patricia Kanakis an employee of that organization?

A Yes.

Q How long have you been with Care Systems, Sir – what capacity?

A I have been with Care Systems since July 1, 1983 and my current capacity is Executive Vice-President, Chief Financial Officer and Corporate Secretary.

Q Can you give me the background of the company where you are working at this time, what they do?

A Okay.

The company was founded in 1978, privately-held corporation by several entrepreneurs in the latter part of '78, a company by the name of Insureco, Incorporated, which is now a fully-owned subsidiary of Transamerica Corporation, purchased the majority interest in the predecessor corporation, which was Insurance Systems Incorporated.

Insureco held this investment until 1983, then sold the corporation to a group of investors who currently continue to hold the majority of the company.

At the time of the 1987 acquisition by Insureco, I was employed by Pete Marlow Mitchell, Certified Public Accountants, in New York City, later in Los Angeles.

In 1980, I joined Insureco Incorporated, that parent company, and stayed with Insureco until the time that Insurance Systems Incorporated was sold to Ventur Capital Investors (Phonetic Spelling), the Company Care Systems – you asked what our business is – I am giving you a long answer to a short question.

Care System provides automation systems and services to insurance companies, agents and brokers, nationally.

. . .

Q Do you have anything to do with obtaining insurance benefits for your employees or employees of care?

A Yes, I do.

Q What do you have to do as far as that is concerned?

A My responsibility is in the acquisition of insurance policies for employees and for the company as a whole, I deal with an insurance broker who actually handles the one-on-one negotiating with the companies.

I rarely if ever have communications with the company, with the insurance company.

Q Do you try and get good benefits for your employees and you rely on your broker to go out and check the marketplace and –

A Yes, my broker is an independent broker and represents companies and brings to me a proposal each year or in the case of markets where there is volatile changes, brings me information several times a year in order to see what the best program for our employees is, both from the covered standpoint and cost standpoint.

Q The underlying accident, which is the subject matter of this lawsuit, occurred in November, 1983.

Your company was called ISI at that time.

A The company was called Insurance Systems Incorporated, yes.

Q And Patricia Kanakis was an employee of the company at the time?

A To the best of my knowledge, yes.

Q By whom did your employees have health benefits with that company or with – for your company?

A At that time we were covered by Mutual of New York for our life – some of our life and our health insurance, in addition to which we were covered by Standard Insurance Company of Oregon for disability, life, accidental death and dismemberment. (R.T. 318-321.)

* * *

Q Do you know whether Mrs. Kanakis had her husband on the policy?

A The only information I have on that is what comes from a document that was produced for purposes of this case, which is an application that Mrs. Kanakis filled out and from my reading of that application, it appears that her husband was added as a dependent. (R.T. 323).

* * *

Q By Mr. Castleberry: You were the man in charge at that time in handling the insurance needs of your company?

A Shortly after joining the company, in July, I was – I had implied responsibility for handling the relationship between our company and benefit bank coordinators.

Q This was not a self-funded –

A No, it was not.

Q No committees.

A No formal committees but we managed the company as a democracy in many fashions.

Q Do you know anything about ERISA?

A Very little.

Q Let me show you a document marked as 23, a November 15, 1983, letter addressed to you, from MONY. (R.T. 325-326).

* * *

Q By Mr. Castleberry: Let me show you a document marked 23.

The Court: 24 would be your next number.

Mr. Castleberry: I'm sorry, 24.

Has the title "Mutual of New York, Summary of Certain Provisions of Employee Retirement Income Security Act."

It is one, two, three, four, five pages long. Do you have a copy of that in your file?

A I have that with me, yes.

. . .

Q Would you mark 24 in the bottom right-hand corner – Well, we will use yours, if that is all right.

Do you remember seeing that document?

A I retrieved this document from our file at our deposition – my deposition.

Prior to that point, I don't recall ever seeing it.

Q Do you know if any of the items on this particular document were compiled with –

. . .

The witness: I need to read through here and respond one by one.

Mr. Pierik: I will also object, lack of foundation.

The Court: If you know, you may answer, sir.

The witness: Firstly, on the named fiduciaries, I mentioned earlier I don't know if there were fiduciaries.

There were people in my company that had responsibility for the relationship but as a title, fiduciaries, I don't know if it was ever formalized.

Q The people in your company would see that the premiums were paid, is that right?

A Yes.

Q The name changes were made, addresses changed?

A Yes.

Q Adding or subtracting a dependent, something of that nature; is that right?

A Yes.

Q If he had a claim, they would forward onto the broker or company.

A We would not see it. It would go off to the company.

Q If somebody wasn't getting paid by Mutual of New York, your company wouldn't handle it?

A To the extent it was not being paid by Mutual of New York, they would come to our personnel and voice a concern or complaint and the personnel department would then interface with our broker and then, from that point, the broker would handle all of the leg work in determining the resolution to that problem.

Your company would pass it on to someone else, either directly or directly to the company, would not go directly to Mutual Life; is that it?

A Please rephrase that.

Q Your company, for the most part, interfaced directly with Mutual Life, would they?

A No.

Q Is that correct?

A That is correct.

Q They, if there was a complaint, they would pass it on to the broker?

A Yes.

Q You relied on your broker to get you good coverage?

A Our broker is outstanding. We have been using him for the predecessor company since 1980 and continue to use him.

Q Did you believe at the time frame, November 1983, you had an ERISA policy?

Mr. Pierik: Objection –

Mr. Castleberry: Or did you know?

Mr. Pierik: Objection, irrelevant, lack of foundation.

The Court: I take it this is preliminary, Mr. Castleberry:

Mr. Castleberry: Yes, your honor.

The Court: The objection is overruled; you may answer, if you know.

A I don't know.

Q By Mr. Castleberry: Do you have a two-page document dated July 31st, 1983?

. . .

Q By Mr. Castleberry: Did you produce that letter, sir?

A I believe I did.

Q This – this letter dated July 31st or was it written by someone from Mutual Life?

A This letter, to the best of my knowledge, was not drafted by somebody in our company; it was either something that was generated by Mutual of New York or Benefit Plan Coordinators. I don't recall which.

The Court: Now, then, a moment ago you said you produced it.

Are you talking about the same document, when you say MONY produced it or someone else other than you produced it?

Q By Mr. Castleberry: You didn't mean you produced, you are bringing it?

A I thought said produced, that I produced at the deposition or am I producing here.

We did not authorize this.

Q Do you have any idea whether that document was ever sent to Patricia Kanakis or any of the employees of Insurance Systems Incorporated?

A I could not say I know it was given or distributed to her, but I could say that it was probably – a speculation.

Q I don't want you to speculate, sir.

You couldn't say.

A Couldn't say. (R.T. 328-333)

* * *

Q By Mr. Pierik: Mr. Ohrnstein, before our break, I was directing your attention to Exhibit 225, which is the same as Exhibit C, the announcement to your employees, July 31, 1983 – do you have those exhibits in front of you?

A Yes.

Q Directing your attention to the first sentence of the third paragraph which, let me read it to you.

> "This announcement and the accompanying booklet are designed to meet the summary plan description requirement of the Employment Retirement Income Security Act, commonly known as ERISA."

Do you see that entry in the document?

A Yes.

Q Does that refresh your recollection as to whether or not the mutual policy was, according to your understanding, an ERISA policy?

A No, it does not.

Q Do you know one way or the other whether this was – or you have an understanding one way or the other whether this was an ERISA plan?

A I don't.

Mr. Pierik: Thank you. (R.T. 356-357.)

* * *

Q You had a file specifically for Mutual of New York?

A Yes, I did.

Q Were exhibits 24, G and H in that file?

A 24, I believe – was it of that file during our deposition when you asked if there were other documents dealing with Mutual of New York – I don't know why these were in here.

The Court: In where?

The witness: Inside my book.

The Court: Inside your deposition transcript?

The witness: Yes.

Q By Mr. Pierik: Did you put them there?

A I did – I think, when, during our deposition, when the ERISA question started coming was a – this is chief financial officer of my company – I wanted to know what is this ERISA thing, what is this all about, so I found these documents in that generic group insurance file and, like I say, my reading of the deposition, they were left in there. (R.T. 363)

* * *

TESTIMONY OF PATRICIA KANAKIS

Q By whom are you employed?

A Insurance Systems Incorporated. They have recently, in the last year, changed their name to Care Systems. (R.T. 199.)

* * *

Q By Mr. Castleberry: Did you make a – or receive a folder from your company about the benefits under that policy?

A Yes, I did.

. . .

Q By Mr. Castleberry: Does that appear to be the document that you received?

A It does.

Q Who did you receive that from?

A My personnel director through my work.

Q Did you ever read that at any time before your husband's accident?

A I looked through it.

Q Do you remember receiving any of the documents at any time prior to your husband's accident about the benefits under that policy?

A Not that I recall.

Q Did you discuss it with anybody before your husband's accident, what benefits you would have?

A No.

Q Did you ask that your husband be covered under that policy?

A Yes, I did. (R.T. 201-202).

* * *

Q You have had a chance to look at that particular booklet since the accident, haven't you?

A Yes, I have.

Q Is there anything within that booklet that mentioned the word "ERISA"?

A No.

I have never heard of that term before.

Q Anybody from your company ever discuss the term "ERISA" with you?

A Absolutely not. (R.T. 205)

* * *

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No. 90-327

OCT 11 [illegible]

JOSEPH F. SPANIOL, JR.

[illegible]

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

THE MUTUAL LIFE INSURANCE COMPANY OF NEW YORK,
NANCY A. HIORTDAHL and DON LUHRSEN,
Petitioners,

v.

TELLY KANAKIS and PATRICIA KANAKIS,
Respondents.

On Petition for a Writ of Certiorari to the Supreme Court of California

PETITIONERS' REPLY BRIEF

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PETITIONERS' REPLY BRIEF

Petitioners, The Mutual Life Insurance Company of New York, Nancy A. Hiortdahl, and Don Luhrsen (collectively, "Mutual Of New York"), respectfully submit this Reply Brief in further support of their Petition for a Writ of Certiorari to the Supreme Court of California.

I. RESPONDENTS BLATENTLY MISSTATE THE HOLDINGS OF THE SEVENTH AND NINTH CIRCUITS IN SUPPORT OF THE STATE COURT'S NOVEL INTENT REQUIREMENT

Respondents have misstated the relevant holdings of the Seventh and Ninth Circuit Courts of Appeals. Respondents state (Brief in Opposition ("Brief in Opp."), p. 12) that the California Court of Appeal's requirement that an employer intend to create a plan to be governed by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 *et seq.* (1982)

("ERISA") is supported by the Seventh Circuit in *Wayne Chemical, Inc. v. Columbus Agcy. Serv. Corp.*, 567 F.2d 692 (7th Cir. 1977), (upon which the trial court relied) and that *Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732 (7th Cir. 1986), (the case cited by Petitioners) further supports an intent requirement.

While the *Wayne Chemical* employer had originally purchased group medical insurance for its employees, its agents (without the employer's prior consent) transferred the program to an unauthorized insurer purporting to establish a multi-employer trust. The court in *Wayne Chemical* determined that the employer had no knowledge of the existence of the plan purportedly established by the trust or of the trust itself and "never entered into an agreement to establish any plan." *Wayne Chemical, Inc. v. Columbus Agcy. Serv. Corp., supra,* 567 F.2d at 699. The court, therefore, held that in order for an employer to become a participant in, or establish or maintain a plan, the employer must *intend* to form an employee benefit plan. The decision, however, did not impose a further requirement that the employer must intend that the plan be governed by ERISA.

Respondents' quote from *Ed Miniat* (Brief in Opp., p. 12) is misleading because it conveys the impression that the court required employer intent to create a plan governed by ERISA; when in fact an employer need only intend to provide benefits to its employees. The excerpt must be read in its context, which is as follows:

> At most the cases suggest that, when the sole employee of a corporation, for that employee's own benefit or for that of his or her family, subscribes to a trust, the necessary *intent* on the part of the corporation *to provide benefits* for its employees may be lacking. Thus, although *Donovan* and *Taggart* are not controlling here, they do support the defendant's broader contention that we should examine the corporation's intent. In the case before us the corporation has via a written agreement, established its *intent* potentially *to provide benefits* to all salaried employees. This is not a case, like *Taggart*, in which a

> corporation arguably failed to express the necessary intent.

Ed Miniat, Inc. v. Globe Life Ins. Group, Inc., supra, 805 F.2d at 741 (emphasis added). Respondents can not dispute the fact that Mrs. Kanakis' employer, Insurance Systems Incorporated ("ISI"), intended to provide benefits to its employees. In fact, in its announcement, ISI stated:

> It gives us considerable pleasure to announce to you that we have completed arrangements for a plan of Group Insurance offering benefits for you and your dependents.
>
> Our Plan is known as the Insurance Systems, Incorporated Employee Benefit Plan and is being underwritten under a group insurance contract issued by Mutual of New York . . . .

Appendix to Petition ("App.") at 46a.

Respondents cite the California Court of Appeal's misplaced reliance on *Kanne v. Connecticut Gen. Life Ins. Co.*, 859 F.2d 86 (9th Cir. 1988), amended on denial of rehearing, 867 F.2d 489 (1988) (en banc), cert. denied, 109 S.Ct. 3216 (1989), as authority for their assertion that the Ninth Circuit imposes an ERISA plan intent requirement.

In its unpublished opinion,* the California Court of Appeal cited *Kanne* as authority for its novel holding that "as a prerequisite to the creation and existence of an ERISA plan, the employer *must intend to create and to participate* in such a plan." App. at 15a; emphasis added. *Kanne* does not support the California court's holding.

---

* Respondents argue that the unpublished opinion of the California Court of Appeal has no precedential value and cannot conflict, therefore, with the numerous federal cases that impose no requirement of employer intent or administrative activity. Respondents imply that a California state court may effectively preclude review of its decision by declaring that the decision not be published. That argument is frivolous. The Court will reverse state court opinions that conflict with federal law whether they are published or unpublished. *See Perry v. Thomas*, 482 U.S. 483 (1987) (reversing an unpublished opinion of the California Court of Appeal, Second Appellate District). The fact that a decision is unpublished "carries no weight in [the Court's] decision to review the case." *Commissioner of Internal Revenue v. McCoy*, 484 U.S. 3, 7 (1987), rehearing denied 484 U.S. 982 (1987).

The California court extended *Kanne's* reference to a plan brochure "evidencing the intent to create an ERISA plan" in the context of a discussion relating to whether the multi-employer trust was merely advertising the group insurance or endorsing the program within the meaning of Department of Labor regulations (29 C.F.R. § 2510.3-1(j)(3)) to a holding that an employer's intent is a "prerequisite" to the creation of an ERISA plan. The California court's blatently contrived holding is not supported by any legal authority in the Ninth Circuit or of this Court.

Mutual Of New York's reliance on *Shaw v. Delta Airlines*, 463 U.S. 85 (1983), is appropriate. This Court, in *Shaw*, held that subjective intent cannot supplant objective criteria to determine whether a plan is maintained "solely" for the purpose of compliance with ERISA. In substantiating the California court's holding, contrary to *Shaw*, that the subjective intent of an employer is a factor to be considered, Respondents vehemently contend (i) that an officer of ISI had no knowledge whether ERISA governed the ISI Plan; (ii) that there is no proof that the ISI letter to employees (describing the ISI plan as being designed to meet the requirements of ERISA) and the booklet entitled "Group Insurance Benefits" (App. 46a-72a) were distributed to the employees of ISI, and (iii) that those documents were not drafted by ISI. Brief in Opp., p. 4. This evidence was the basis on which the jury found a lack of employer intent to establish an ERISA plan. Accordingly, Respondents have inadvertently bolstered Mutual of New York's case by proving the materiality of the erroneous jury instruction—an instruction that is contrary to this Court's holding in *Shaw*.

II. RESPONDENTS MISCONSTRUE THE FACTS AND HOLDINGS OF *FORT HALIFAX* AND *KANNE* TO SUPPORT A REQUIREMENT OF ADMINISTRATIVE ACTIVITY BY AN EMPLOYER

This Court in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), determined that a one-time severance payment did not implicate the concerns of ERISA, as it did not involve the administration of a plan and the obligation of an employer to pay benefits on a regular basis. The lack of administrative activity in *Fort Halifax* was cited as authority by the California Court of Appeal to invent a requirement that to create an ERISA plan the employer must perform the plan administrative duties *to the exclusion of all others*. Such a holding is inconsistent with the mandates of ERISA § 3(1), 29 U.S.C. § 1002(1), and distorts this Court's holding in *Fort Halifax*.

Citing its summary affirmance of lower court decisions in *Holland v. Burlington Industries, Inc.*, 477 U.S. 903 (1986), and *Gilbert v. Burlington Industries, Inc.*, 477 U.S. 901 (1986), this Court noted in *Fort Halifax* that severance payments from a benefit plan paid from general assets of an employer would implicate the concerns of ERISA and constitute an ERISA plan. *Fort Halifax Packing Co. v. Coyne, supra*, 482 U.S. at 17. The distinction noted by the Court was that in the *Burlington* cases "there was a 'plan' and the only issue was whether the type of benefits paid by that plan are among those covered by ERISA." *Id.* at 18. In holding that ERISA governed, the Court reasoned that "if an employer has an administrative scheme for paying benefits, it should not be able to evade the requirements of the statute

[ERISA] merely by paying those benefits out of general assets." *Id.*

Under the holding of the California Court of Appeal in this case, employers may evade the requirements of ERISA simply by delegating performance of the administrative plan functions to a third party. Certainly, *Fort Halifax* does not support such a result.

In their final effort to support the opinion of the California Court of Appeal, Respondents argue that *Kanne* requires that an employer must administer a plan for it to be governed by ERISA.

The plaintiffs in *Kanne* argued on appeal that the group health insurance plan administered by a multi-employer trust was not an ERISA plan. The Ninth Circuit rejected the argument, as it found that the trust did not merely "advertise the group insurance, but rather, as administrator of the plan, 'endorses' it within the meaning of 29 C.F.R. 2510.3-1(j)(3)." *Kanne v. Connecticut General Life Ins. Co., supra*, 867 F.2d at 493.

Understandably, Respondents merely cite to the California Court of Appeal's incorrect analysis of *Kanne* (Brief in Opp., pp. 16-18). The California court, however, incorrectly reasoned that because the ISI Plan did not resemble the multi-employer plan in *Kanne*, the ISI Plan could not be governed by ERISA. A multi-employer trust, however, is but one vehicle used to establish employee benefit plans. ERISA § 3(5), 29 U.S.C. § 1002(5). There is no dispute that ISI, as the plan sponsor, endorsed the plan, designated the administrator, paid premiums for employees and, as such, did more than simply advertise the program. App. at 46a-47a.

The *Kanne* court searched for administrative activity by ***any entity***, and found that the employer group was the administrator. The court did not hold that the employer had to be involved in administrative activity and, in fact, specifically noted that the Kannes had incorrectly assumed that the employer's functions with respect to the plan determined ERISA coverage. *Kanne v. Connecticut General Life Ins. Co., supra*, 867 F.2d at 492-493.

The contrived nature of the California court's holding cannot be understated. The court ignored the existence of an employee benefit plan and misapplied the holdings of this Court and that of the Ninth Circuit to justify a windfall to the Respondents. It then purportedly neutered the holding by declaring it to be "unpublished." Although Mr. Kanakis suffered serious injury, the California court's willingness to yield to the emotional pleas of Respondents (App. at 3a-4a) does not make sound law. The decision should not be permitted to stand.

CONCLUSION

For the foregoing reasons and for the reasons set forth in the Petition and Brief Amici Curiae of American Council of Life Insurance and Health Insurance Association of America, a writ of certiorari should issue to examine the denial of a petition for review by the Supreme Court of California.

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On Petition for a Writ of Certiorari to the Supreme Court of California

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE OF AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE

The American Council of Life Insurance ("ACLI") and the Health Insurance Association of America ("HIAA") hereby respectfully move for leave to file the attached brief *amici curiae.* The questions presented are issues of great importance under The Employee Retirement Income Security Act of 1974 (ERISA), in which *amici,* as well as ERISA plan beneficiaries and sponsors, are vitally interested. *Amici* have sought permission of the parties to file this brief. Petitioner has consented; respondent has refused consent.

Amici are the largest life and health insurance trade associations in the country. HIAA represents the interests of over 300 member companies, which underwrite or administer more than 85 percent of the health and disability insurance written by insurance companies in the United States. Over 90 million Americans are covered by insurance provided by HIAA members, primarily through employee benefit plans. ALCI represents the interests of over 600 member life insurance companies, which presently hold approximately 94 percent of the life insurance in force in legal reserve life insurance companies in the United States, much of which is issued to or through employee benefit plans.

The questions presented in the instant case are of substantial importance to ACLI and HIAA and their member companies, and to ERISA plan sponsors, participants and beneficiaries nationwide. The decision of the California Court of Appeal is the latest in a series of similar decisions by the California appellate courts which misconstrue this Court's precedent and other federal statutory and case law. These cases have significant consequences for all parties to insured employee benefit plans; they give employers total control, depending on their subjective intent and their choice whether to delegate administrative duties, over whether their plans will be subject to federal regulation.

The brief submitted by ACLI and HIAA urges this Court to grant *certiorari* to settle two important questions of federal law upon which the court below reached the wrong conclusions: (1) whether an employer must be directly and actively involved in the administration of an employee welfare benefit plan for such a plan to be subject to regulation under ERISA, or whether an employer may delegate administrative responsibility to an insurer or other third party without evading federal regulation, and (2) whether an employer must evidence an intent to establish a plan governed by ERISA for a welfare benefit plan to be subject to federal regulation. To date, the California courts of appeal's answers to these questions conflict with federal law and threaten to disrupt the uniform national scheme of federal regulation of employee benefit plans that was intended by Congress when it enacted ERISA.

The insurers represented by HIAA and ACLI have a vital interest in the outcome of this case. HIAA and ACLI can provide the Court with a broad perspective on the issues by virtue of their extensive involvement in ERISA employee welfare benefit plans nationwide. They have provided this Court with *amicus* briefs in recent cases concerning other important issues under ERISA, for example *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). They respectfully request permission to file their brief as *amici curiae.*

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---

BRIEF AMICI CURIAE OF AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA

INTEREST OF AMICI

The interest of *amici* American Council of Life Insurance and Health Insurance Association of America is set forth in their accompanying Motion for Leave to File Brief as Amici Curiae.

SUMMARY OF ARGUMENT

This Court should grant *certiorari* in this case to settle two important questions of federal law under The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. Sections 1001, *et seq.* The first question, whether an employer must be actively involved in the administration of an insured employee welfare benefit plan in order for the plan to be subject to federal regulation under ERISA, arises from the consistent misinterpretation by California courts of appeal of this Court's decision in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987). California courts, including the court below, have erroneously extracted from *Fort Halifax* a rule that an insured employee welfare benefit plan is not governed by ERISA unless the employer is directly and actively involved in the administration of the plan. This requirement was not articulated by this Court in *Fort Halifax*, and is inconsistent both with the tests for ERISA coverage articulated by the federal courts of appeals, *see*, e.g., *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982), and with the regulations promulgated under ERISA by the Department of Labor, 29 C.F.R. 2510.3-1(j), which permit employers to delegate administration of such plans to insurers or other third parties. This Court should grant *certiorari* in order to resolve this important question raised by the lower courts' misunderstanding of *Fort Halifax*.

This Court should address the second question, whether an employer must evidence an intent to establish an ERISA plan in order for ERISA to govern the plan, to resolve a conflict between the California Court of Appeal and the majority of federal courts of appeals, and to close a potentially major loophole in the application of ERISA to employee benefit plans. If the employer's subjective intent is a test of whether ERISA governs the plan, employers will be free to "opt out" of ERISA coverage simply by ignoring its dictates or deciding that they do not elect to have ERISA coverage. This would contravene one of the principal purposes of ERISA, which is to protect employees and their dependents under a national scheme of federal regulation from improper or imprudent benefit plan administration. *See, Fort Halifax Packing Co. v. Coyne, supra*, 482 U.S. at 7-16.

The imposition by the California Court of Appeal of both requirements, employer administrative activity and subjective intent to be governed by ERISA, threatens to undermine the uniform, comprehensive federal regulatory scheme that Congress sought to impose on employee benefit plans nationwide when it enacted ERISA. *See, Shaw v. Delta Air Lines Inc.*, 463 U.S. 85 (1983). This Court should grant *certiorari* in order to resolve the conflict between the California courts of appeal and federal courts, including this Court, and to settle these important questions of federal law.

ARGUMENT

I. THIS COURT SHOULD GRANT CERTIORARI TO SETTLE AN IMPORTANT QUESTION OF FEDERAL LAW BY UNEQUIVOCALLY STATING THAT DIRECT EMPLOYER ADMINISTRATION OF AN INSURED EMPLOYEE WELFARE BENEFIT PLAN IS NOT NECESSARY FOR SUCH A PLAN TO BE REGULATED BY ERISA.

In an attempt to avoid ERISA preemption of employee benefit claims, the state court of appeal below, following the lead of other California appellate court opinions,[1] has misinterpreted and misapplied this Court's opinion in *Fort Halifax Packing Co. v. Coyne*, *supra*, erroneously declaring that direct employer administration of an insured employee welfare benefit plan is necessary to the establishment and maintenance of an ERISA plan. This Court should take this opportunity to place its imprimatur upon the reasoning of the majority of the federal courts of appeals, which have held that an employer's adoption of a group insurance plan for its employees creates an ERISA plan, so long as "from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for recovery of benefits."[2]

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[1] *Sayble v. Blue Cross of Southern California*, 88 Cal.App.3d 1108 (March 20, 1989) (Rev. den. by Cal. Supreme Ct. June 8, 1989; directed not to be published in Official Reports); *Rizzi v. Blue Cross of California*, 206 Cal.App.3d 380, 390 (1988).

[2] This imprimatur is particularly important because the state appellate courts in California are not obligated to adhere to deci-

Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982) (*en banc*). *See also Kanne v. Connecticut General Life Insurance Co.*, 859 F.2d 96, 98 (9th Cir. 1988); *Ed Miniat, Inc. v. Globe Life Insurance Group*, 805 F.2d 732, 738 (7th Cir. 1986), *cert. den.*, 482 U.S. 915 (1987); *Roe v. General American Life Insurance Co.*, 712 F.2d 450, 452 (10th Cir. 1983); and *Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988). Despite the lower court's reliance on *Fort Halifax*, neither this Court in *Fort Halifax* nor the ERISA statute itself directly addresses any requirement of employer administration of an insured plan as a prerequisite to ERISA coverage.

In deriving from *Fort Halifax* a requirement of employer administration of insured plans, the court below has misstated and mis-analyzed the facts of that case, as well as its holding. *Fort Halifax* imposes no such requirement. *Fort Halifax* involved an employer that attempted to avoid a Maine statute requiring it to pay a one-time severance benefit to employees of plants which closed or relocated. The employer argued that ERISA preempts any state law pertaining to a type of employee *benefit* listed in ERISA, including severance benefits. This Court rejected the employer's argument for three reasons: (1) The interpretation urged by the employer was contrary to the plain language of ERISA's preemption provision, which refers not to employee *benefits* but to employee benefit *plans*. 482 U.S. at 7-16. (2) The Maine statute required only a one-time payment, and therefore it had no administrative scheme that would implicate the concerns of the preemption provision. *Id.* (3) The Maine statute did not implicate the fiduciary concerns of ERISA. This Court stated that "[o]nly

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cisions of intermediate federal courts on federal question issues, but obviously must follow a decision of this Court on such an issue. *People v. Bradley*, 1 Cal.3d 80, 86 (1969); *Debtor Reorganizers Inc. v. State Board of Equalization*, 58 Cal.App.3d 691, 696 (1976).

'plans' [as opposed to one-time benefit payments] involve administrative activity potentially subject to employer abuse." *Id.*, at 16. Since the obligation to pay a *one-time* severance benefit involved no such activity, there was no occasion for such abuse. *Id.*

Thus, the focus of *Fort Halifax* was on the difference between a *one-time* employee benefit that required no ongoing administration by *anyone*, and *ongoing* benefit plans that have an administrative scheme that may be regulated. *Fort Halifax* did not focus on, and did not purport to express, what specific administrative activities must be undertaken in order for a plan to be covered by ERISA. More importantly, *nothing* in *Fort Halifax* requires that the administrative duties be performed by the *employer*, as opposed to a third party to whom the employer may delegate them. *Fort Halifax* makes clear that the concerns of ERISA's preemption and fiduciary provisions are implicated by the *existence* of an administrative scheme, not by who administers that scheme.

The state court below, consistent with an apparent trend among the California appellate courts,[3] ignored that the benefit involved in *Fort Halifax* required no administration whatsoever, *by anyone*, and focused only on the fact that the employer in *Fort Halifax* actually performed no administrative duties subject to ERISA. The appellate court's reliance on *Fort Halifax* is clearly misplaced. *Fort Halifax* simply *did not* decide nor declare that where an employer provides benefits to its employees through insurance, what would otherwise be an ERISA plan loses ERISA status if the employer delegates administrative duties to the insurer or other third party.

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[3] See, e.g., *Sayble v. Blue Cross of Southern California,* 88 Cal. App.3d 1108 (March 20, 1989) (Rev. den. by Cal. Supreme Ct. June 8, 1989; directed not to be published in Official Reports). ("[T]he existence of an ERISA plan depends on the extent to which the employer is involved in the administration of the benefit program so as to implicate the concerns which give rise to ERISA. [. . .] Due to the lack of participation by [the employer] in the administration of the subject insurance benefit, the regulatory concerns of ERISA are not implicated."); *Rizzi v. Blue Cross of California,* 206 Cal.App.3d 380, 390 (1988) ("An employer may have (but has not necessarily) established an ERISA plan if his main involvement is to contribute to the payment of premiums. [. . .] The ultimate determination depends on an evaluation of all the circumstances, keeping in mind ERISA's purpose of regulating an *employer's administration* of benefit plans.")

As Petitioners have ably pointed out in their Petition, ERISA expressly contemplates the extensive role insurers necessarily play in the administration of insured employee benefit plans and assumes that, generally, administrative duties can and will be delegated to third parties.[4] *Petition*, at 10 and 11. In addition, the regulations under ERISA expressly contemplate administration of claims by the insurer under an insured plan. For example, 29 C.F.R. Sections 2560.503-(1)(c) and (g)(2) discuss the mechanics of integrating an insurer's claim procedures with those required by ERISA, and impose fiduciary responsibility under ERISA on an insurer processing such claims.

The California courts of appeal, including the court below, are misusing this Court's opinion in *Fort Halifax* in an effort to restrict the scope of ERISA preemption of state laws relating to employee benefit plans. Moreover, the California courts are apparently unwilling to follow clear intermediate federal authority. There exists a pressing need, therefore, for this Court to grant the instant Petition for Writ of Certorari, to resolve an important question of federal law in an area where relevant federal precedent is being ignored and misapplied by the California appellate courts. That important question of federal law is whether an employer that provides welfare benefits through insurance may delegate administrative responsibility for the plan to an insurer or third party, or whether the employer must be directly involved in administration of the plan for the plan to be subject to ERISA regulation.

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[4] A recent study indicates that 93% of employer-sponsored health benefit plans have claims administered by entities other than the employer, such as insurers and professional third-party administrators. 1988 Foster Higgins Health Care Benefits Survey 24.

II. BY REQUIRING EMPLOYER "INTENT" TO ESTABLISH AN ERISA PLAN, THE CALIFORNIA COURT HAS CREATED A LOOPHOLE IN FEDERAL LAW WHICH CONFLICTS WITH DECISIONS OF FEDERAL COURTS OF APPEALS AND WHICH WILL PERMIT EMPLOYERS TO "OPT OUT" OF ERISA COVERAGE, UNDERMINING THE UNIFORM FEDERAL SCHEME OF REGULATION ESTABLISHED BY CONGRESS.

The California court has created a remarkable, and potentially huge, loophole in federal law by requiring that an employer demonstrate an "intent" to establish an ERISA plan in order for ERISA to govern the plan. This requirement permits an employer to "opt out" of federal regulation simply by determining unilaterally that it does not "intend" to have an employee benefit plan governed by ERISA. Such a choice could effectively remove most California benefit plans from the uniform national regulatory scheme that Congress expressly articulated as its principal goal when it enacted ERISA. *See, Shaw v. Delta Air Lines Inc.*, 463 U.S. 85, 105, (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, (1981).

This Court should grant *certiorari* in order to address this issue because the vast majority of employee welfare benefit plans could be affected if courts continue to misunderstand the fundamental concept of how an employee welfare benefit plan subject to ERISA can be established. Unfortunately, the California court's erroneous intent requirement was derived from misleading language in several federal circuit court opinions, which may continue to foster similar misperceptions and avoidance of federal regulation.

The California court misread *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 567 F.2d 692 (7th Cir. 1977) and *Taggart v. Life & Health Benefit Administration*, 617 F.2d 1208 (5th Cir. 1980), to require that an employer intend to establish an ERISA governed plan as a prerequisite to ERISA coverage. Both of these early cases struggled with the application of ERISA to circumstances where an employer selects as the funding mechanism for health benefits a multiple-employer insurance trust that is not itself an ERISA plan.[5] Subsequent cases have clarified this question. *See*, e.g., *Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988); *Donovan v. Dillingham*, 688 F.2d F.2d 1367, 1375 (11th Cir. 1982) (*en banc*). However, the California court, taking language out of the context of the facts and legal issues of the cases, has extracted a rule which, if followed, will make ERISA regulation of employee benefit plans optional at the whim of the employer.

The correct approach, which should be articulated directly by this Court, was stated in *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617 (9th Cir. 1987). The Court stated,

> An employer . . . can establish an ERISA plan rather easily. Even if an employer does no more than arrange for a "group-type insurance program," it can establish an ERISA plan, unless it is a mere advertiser who makes no contributions on behalf of its employees.

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[5] No multiple employer insurance trust is involved in this case, although the choice between insurance purchased directly from an insurer and insurance purchased through subscription to a multiple employer trust is of no consequence in the determination of whether the *employer* has established an employee welfare benefit plan governed by ERISA. *See, e.g., Kanne v. Connecticut General Life Insurance Co.*, 867 F.2d 489 (9th Cir. 1988); *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617 (9th Cir. 1987).

809 F.2d at 625. *See, Donovan v. Dillingham, supra,* 688 F.2d at 1373. (An ERISA plan "is established if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits".)

Substantial guidance in determining whether an employer that has arranged for group insurance benefits has established an ERISA-governed employee welfare benefit plan is found in regulations promulgated by the Department of Labor. 29 C.F.R. Section 2510.3-1(j). This Court has acknowledged the deference to be accorded to the reasonable regulations of the Secretary of Labor in the interpretation of ERISA. *Massachusetts v. Morash,* —— U.S. ——, 109 S.Ct. 1668, 104 L.Ed.2d 98 (1989).[6]

The Department of Labor regulations set forth four criteria, *all* of which must be present, in order for a group insurance arrangement *not* to be governed by ERISA: (1) the employer makes *no contribution* toward premiums; (2) participation by employees in the program is *completely voluntary*; (3) the employer *does not endorse* the program, and simply permits an insurer to publicize the program to its employees and collects premiums for the insurer through payroll deductions or the like; and (4) the employer receives *no consideration* in connection with the program other than reasonable compensation for its administrative costs in collecting premiums for the insurer. 29 C.F.R. Section 2510.3-1(j). *See, Kanne v. Connecticut General Life Insurance Co.,* 867 F.2d 489, 492 (9th Cir. 1988). (All four criteria must be met in order for a group insurance arrangement to be exempt from ERISA coverage.)

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[6] Congress specifically empowered the Department of Labor to issue regulations under ERISA, and therefore the Secretary's construction of the statute is controlling unless the promulgation of the regulation at issue was an abuse of discretion, arbitrary or capricious, or contrary to the statute. 29 U.S.C. Section 1135; *See, Batterton v. Francis,* 432 U.S. 416, 428 (1977); *Buczynski v. General Motors Corporation,* 616 F.2d 1238, 1242-43 (3rd Cir. 1980).

As the *Donovan* court pointed out, in determining whether an employer's plan is governed by ERISA, the focus of the inquiry is whether the decision to establish a plan or program "has become a reality." 688 F.2d at 1373; *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*, 805 F.2d 732, 739 (7th Cir. 1986). Where an employer has elected to provide a medical insurance plan for the benefit of its employees, has paid some or all of the premiums for that insurance, and has done more than simply permit an insurer to advertise an insurance program to its employees, the decision to establish a plan has clearly "become a reality." It is simply incorrect to conclude that a plan is not governed by ERISA because the employer was unaware that ERISA existed or determined that it did not wish to have ERISA governance. Giving the employer effective control over whether to be governed by federal regulation would permit employers, by ignorance or by design, to thwart the protections ERISA affords millions of working Americans against improper or imprudent plan administration.

It is important that this Court grant *certiorari* in this case to uphold the intent of Congress that employee benefit plans throughout the United States, including insured plans, be subject to a single, uniform, comprehensive scheme of federal regulation. In enacting ERISA, Congress was emphatic that it be broadly applied. As the Senate reported:

> It is intended that coverage under the Act be construed liberally to provide the maximum degree of protection to working men and women covered by private retirement programs. Conversely, exemptions should be confined to their narrow purpose.

Senate Report No. 93-127, *reprinted in* 2 U.S. Code Cong. & Admin. News, p. 4854 (1974).

This Court should not permit employers to circumvent ERISA's broad preemptive effect, and to "opt out" of the comprehensive scheme of federal regulation enacted by Congress, simply by not "intending" to establish an ERISA-governed plan. A definitive statement on this issue is needed to stop the California courts from misconstruing federal case authority and creating a requirement that could completely eviscerate the broad application of ERISA intended by Congress.

CONCLUSION

For the foregoing reasons, *amici* urge this Court to grant the Petition for Writ of Certiorari.

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